

Today's Date: \_\_\_\_\_

**MEDICAL HISTORY QUESTIONNAIRE**  
(Please print)

**Please complete this questionnaire and either mail it to the office at the above address, fax it to the office or bring it with you to your appointment. Thank You.**  
**In order to better serve all of our patients, new patient appointments broken without 24-hour notice will not be rescheduled.**

**Patient Name:** \_\_\_\_\_ **Marital Status M / W / S / D**

**Patient Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Chief Complaint(s)/Reason(s) for appointment:** \_\_\_\_\_

**Allergies (drug or other):** \_\_\_\_\_

List All Hospitalizations, Surgeries, or Major Illnesses	Year and Reason

**Medications** (please include name & dosage, include over the counter medications and supplements):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you ever had any of the following (circle Yes or No, or leave blank if uncertain)?**

AIDS or HIV	Yes No	Anemia	Yes No	Arthritis	Yes No
Asthma	Yes No	Back Trouble	Yes No	Bladder Infection	Yes No
Bleeding Tendency	Yes No	Bronchitis	Yes No	Cancer	Yes No
Chickenpox	Yes No	Diabetes	Yes No	Diphtheria	Yes No
Epilepsy	Yes No	Glaucoma	Yes No	Heart Disease	Yes No
Hemorrhoids	Yes No	Hepatitis	Yes No	Hernia	Yes No
High Blood Pressure	Yes No	Low Blood Pressure	Yes No	Hives or Eczema	Yes No
Infectious mononucleosis	Yes No	Kidney Disease	Yes No	Measles	Yes No
Migraines	Yes No	Mitral Valve Prolapse	Yes No	Mumps	Yes No
Pneumonia	Yes No	Polio	Yes No	Rheumatic Fever	Yes No
Scarlet Fever	Yes No	Small Pox	Yes No	Stroke	Yes No
Thyroid Disease	Yes No	Transfusions	Yes No	Ulcer	Yes No
Venereal Disease	Yes No	Whooping Cough	Yes No	Blurred Vision	Yes No

Any other diseases please specify here: \_\_\_\_\_

**Family History:** Mother, Father, Siblings, Aunts, Uncles, Grandparents

	Yes	No	Whom
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Mental Illness	_____	_____	_____
Breast Cancer	_____	_____	_____
Ovarian Cancer	_____	_____	_____
Uterine Cancer	_____	_____	_____
Colon Cancer	_____	_____	_____
Other Cancer	_____	_____	_____
Deep Vein Thrombosis	_____	_____	_____
Bleeding Disorders	_____	_____	_____
High Cholesterol	_____	_____	_____
Thyroid Disorders	_____	_____	_____
Osteoporosis	_____	_____	_____
Comments:	_____		

**Review of Systems / Patient's Past Medical History (Circle all that currently apply):**

**GENERAL:** General: Fever or Chills, Night Sweats, Weight loss, Weight Gain, Fatigue,  
Cold or Heat intolerance, Diabetes, Thyroid problems

**HEENT:**

Eyes: Blurred vision, Double vision, Pain Itching, Watering

Ears / Nose / Throat: Ringing in ears, Decreased Hearing, Ear pain or drainage

Runny nose, Congestion, Sneezing, Sore throat, swallowing difficulty

**GASTROINTESTINAL:**

Abdominal pain, Bloating, Belching, Gas, Heartburn, Constipation

Diarrhea, Bloody or Tarry Stool, Change in stool

Consistency of stool (liquid / soft / hard)

Frequency (daily / every other day / biweekly / weekly), # of stools per day \_\_\_\_\_

**CARDIOVASCULAR:**

Chest pain (resting or with exertion), Palpitations (Heart beats fast or funny), Swelling, Swollen ankles,

Leg pain when walking, Fainting or Blacking out, High Blood Pressure

**RESPIRATORY:** Cough (day or night), SOB (rest or with exertion), sputum, and history of asthma / wheezing,  
bronchitis, pneumonia

**GENTOURINARY:**

Urination (frequency of urination / painful urination / bloody urine), History of kidney stones, Sexually  
transmitted diseases, Urinary Tract Infections, Number of sexual partners \_\_\_\_\_ ;

High-risk exposure: yes / no

**MUSCULOSKELETAL:**

Pain or swelling in muscles or joints, weakness

Arthritis, Osteoporosis, Bone fracture / joint injury, Gout

**HEM / LYMPH:** Easy Bleeding or bruising, Lumps or bumps in neck, armpits, groin, breasts or testicles.

**NEUROLOGICAL:** Numbness and Tingling, Fainting, Blackouts, Abnormal Jerking, Repetitious movements,  
history of seizures, tremors, tics

**SKIN:** Acne, Dry, Flaky, Peeling, Rash, Redness, Itching, Recent change in moles/lesions/or birthmarks.

Describe color / location / size: \_\_\_\_\_

**PSYCHIATRIC:** Anxiety, crying episodes, depression, moodiness, paranoia, or phobias

Please list problems not covered elsewhere: \_\_\_\_\_



**Pregnancy History**

Date Month/year	preterm or term delivery	length of labor	birth weight	sex M/F	place of delivery	type of delivery (vaginal, c-section) (forceps, vacuum,)	any complications
--------------------	-----------------------------	--------------------	-----------------	------------	----------------------	--	----------------------

1.							
2.							
3.							
4.							
5.							
6.							

**Miscarriages/ Abortions:**

Date Month/year	how far along
--------------------	------------------

1.	
2.	
3.	

**Comments:** \_\_\_\_\_

\_\_\_\_\_