

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's Date: _____
 Date of last complete physical exam _____, performed by _____

FAMILY HISTORY

List all family medical history by member including cancer, heart attacks, diabetes, high cholesterol, osteoporosis, stroke, blood clotting disorders, etc. Please indicate current age or if deceased at what age and why.

Mother: _____
 Father: _____
 Siblings: _____
 Children: _____

MEDICAL HISTORY

Please check/circle all that apply to you in the past or currently that have required medical treatment.

- | | | |
|---|---|---|
| <input type="checkbox"/> Migraines/Seizures | <input type="checkbox"/> Diabetes | <input type="checkbox"/> IBS/Colon Polyps/Colitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Eye Disease/Surgery | <input type="checkbox"/> Blood/Bleeding Disorder |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> COPD/Emphysema/Asthma | <input type="checkbox"/> Urinary Infection |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney Disease/Infection | <input type="checkbox"/> Muscular Disease/MS |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> GERD/Ulcers | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety/Insomnia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer (type : _____) |
| <input type="checkbox"/> Heart Disease/CAD | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Osteoporosis |

SURGICAL HISTORY

Include type of surgery and approximate date

OBSTETRICAL HISTORY

Total number of pregnancies: _____
 Number of miscarriages: _____
 Number of abortions: _____
 Number of births: _____

Please give details about each birth:

	Birth (most recent)	Birth	Birth	Birth
Date of birth	____/____/____ mm/dd/yyyy	____/____/____ mm/dd/yyyy	____/____/____ mm/dd/yyyy	____/____/____ mm/dd/yyyy
Gestational age (duration of pregnancy)	____ weeks	____ weeks	____ weeks	____ weeks
Route of delivery	vaginal c-section	vaginal c-section	vaginal c-section	vaginal c-section
Weight at birth	____ lbs. ____ oz.	____ lbs. ____ oz.	____ lbs. ____ oz.	____ lbs. ____ oz.
Length of labor	____ hours	____ hours	____ hours	____ hours
Anesthetic				
Complications				

MENSTUAL HISTORY

Age of onset _____

Average # of days in-between **start** of each period _____

Total # days bleeding _____

Do you experience: clots, heavy, moderate, light or scant bleeding?

Do you experience cramping every month during your period that is not controlled? YES NO

Date of last period ____/____/____

Please list types of current or prior contraception used: _____

OTHER MEDICAL PROVIDERS OR HOSPITALIZATIONS

List all medical providers, hospitalizations, ER visits, tests you have had since your last visit/past year: i.e., X-rays, mammograms, ultrasounds, EKG, physical therapist, lab tests, immunizations, etc.

Name of Physician/Hospital	Date	Reason for Visit or Procedure

SYMPTOMS

Do you have now or have you had *within the last year on a recurrent basis?* (check all that apply)

- Change in frequency/severity of headaches
 - Blurred or double vision
 - Excessive thirst
 - Chronic cough/Coughing up blood
 - Wake up at night short of breath
 - Unusual shortness of breath at rest
 - Chest pressure or heaviness
 - Unusual leg/foot pain with exercise
 - Recurrent stomach pain
 - Persistent nausea, vomiting or diarrhea
 - Change in appetite -- Increase / Decrease
 - Unexplained weight loss / weight gain
 - Blood in urine or dark brown urine
 - Leakage of urine w/ cough/sneeze
 - Persistent or worsening back or neck pain
 - Persistent tingling in fingers, hands or feet
 - Itching, scaling, redness or change in mole
 - Serious depression
 - Excessive anxiety or nervousness
 - Current daily stress level Low Moderate High Extreme
- Persistent or severe dizziness _____
 - Unusual dryness or oiliness of skin/hair
 - Unusual increase in amount of urination
 - Snoring/stop breathing w/ sleep _____
 - Difficulty breathing when lying flat _____
 - New/increased swelling of ankles/feet
 - Palpitations or fluttering of heart
 - Persistent difficulty swallowing _____
 - Persistent heartburn or indigestion _____
 - Blood in vomit/stool, or tar-like stools
 - Night sweats/hot flashes/mood swings
 - Persistent pain or burning with urination
 - Significant urge to urinate _____
 - Difficulty starting or stopping urine _____
 - Persistent pain/swelling or heat in joints
 - Persistent muscle weakness in arms/legs
 - Persistent or recurrent rash _____
 - Sleep disturbances _____

PERSONAL DETAILS

Do you or are you ... (Please circle or answer to the best of your knowledge)

Marital status: Married Single Divorced Widowed Dating monogamously Dating several

Have sex with: Men only Women only Both

Sexually involved at this time? No Yes

If yes, what do you use to prevent sexually transmitted diseases? _____

What do you use to prevent pregnancy? _____

Smoke cigarettes, pipe or cigars? Never Not since (month/year) ___/___ Yes

If yes, how old were you when you started _____

How much do you smoke **per day** (packs/day): half pack one pack two or more packs

Drink alcohol, beer or wine? No Yes

If yes, how much do you drink **per day**? Not every day One drink
Two or three drinks More than three

Drink caffeinated beverages (coffee, tea, sodas cups/day)? Not every day One to two
Three to six More than six

Have a special diet (i.e. vegan/vegetarian, no lactose)? No Yes

If yes, what? _____

Exercise: type: _____

frequency: ___/week Duration: _____

SCREENING TEST/QUESTIONS

Do you do regular monthly breast exams? Yes No

Date of last mammogram _____

Date of last pelvic exam _____

Date of last Pap smear _____

Result _____

Have you ever had an abnormal pap smear? Yes No

If yes, when? _____ What was the result? _____

Have you ever had a colonoscopy? Yes No

Have you ever had a bone density scan? Yes No

Have you had lab work for cholesterol, diabetes, thyroid disease, and/or anemia? Yes No

If yes, when? _____ What was the result? _____

Have you been or are you currently abused? Yes No

If yes, was it physical, sexual, verbal, other? _____

Is it still occurring? Yes No

ALLERGIES:

Please list all allergies to medications you have:

MEDICATIONS:

Please list all medications you are currently taking, the dose, frequency, and the doctor who prescribed it:

REASON FOR YOUR VISIT TODAY: _____

How did you hear about us? (Please circle one, and give details if you feel comfortable doing so.)

Magazine advertisement/flyer: _____

Web search: _____

Seminar or event: _____

Family/friend: _____

Hospital/MD referral: _____

Other: _____