



Medical History Questionnaire

Name: _____ Date of Birth: _____

List main reason for today's visit: _____

List any other active problems (include treating physician if applicable): _____

Allergies and reaction: _____

Medications and dosages (please include supplements): _____

Do you feel you have problems with sleep, snoring or daytime sleepiness? Yes No

Would you like to speak with us about this? Yes No

Past medical illnesses (Please place a check by all which applies):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> STD(type) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hepatitis B/C | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Positive TB skin test |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizure | <input type="checkbox"/> Ulcerative colitis |

Other: (please specify) _____

Past Operations/Procedures and/or Hospitalizations (please include date): _____

Family history (please indicate major medical problems; If deceased, please indicate cause of death):

Maternal Grandmother _____

Maternal Grandfather _____

Paternal Grandmother _____

Paternal Grandfather _____

Mother _____

Father _____
 Siblings _____
 Children _____

Social History

Occupation: _____ Marital Status: _____ Children: _____
 Alcohol Use: Yes ___ No ___ How often: _____ Quantity: _____
 Tobacco Use: Yes ___ No ___ Pack per day: _____ How many Years: _____
 Former Smoker: Yes ___ No ___ Pack per day: _____ Year quit: _____
 Other Tobacco/Nicotine: Yes ___ No ___ Type: _____ Quantity: _____
 Other Drugs: Yes ___ No ___ If yes, please specify: _____
 Exposure to asbestos or other hazardous material: Yes ___ No ___ If yes, please specify: _____
 Do you have a living will? Yes ___ No ___
 Healthcare proxy: Yes ___ No ___ If yes, please indicate Name: _____ Relationship: _____

Health Maintenance

Last known Menstrual cycle: _____ Last known Pap Smear: _____
 Last known Mammogram: _____ Last known Colonoscopy: _____
 Last known Prostate Cancer Screening: _____ Last Bone Density scan: _____

Immunizations:

Pneumonia: _____ Flu: _____ Tetanus/TD/Tdap: _____
 Hepatitis A: _____ Hepatitis B: _____

Review of Systems: (Please place a check by all which applies):

	Weight Gain		Weakness		Insomnia		Blood in vomit
	Persistent Cough		Fainting		Mood Swings		Bowel Changes
	Blood in Stool		Frequent urination		Difficulty swallowing		Runny nose
	Headache		Tremor		Nausea		Feeling cold
	Weight loss		Fatigue		Change in vision		Back pain
	Fever		Change in exercise Tolerance		Vaginal discharge/bleeding		
	Chest Comfort		Penis Discharge		Anxiety		Blood in sputum
	Difficult urinating		Breast pain		Change in hearing		Nipple discharge
	Memory Loss		Leg swelling		Depression		Short of breath
	Night Sweats		Pain with intercourse		Heartburn		Diarrhea
	Breast Lump		Trouble breathing		Skin rash		Nose bleed
	Leg pain		Palpitations		Feeling hot		Constipation
	Dizziness		Numbness/Tingling				

Patient Signature: _____ Date: _____

Reason Patient is Unable to Sign: _____ Date: _____