Medical History Questionnaire

New Patient

Name:_____ Date:_____ DOB:_____

How would you like to be addressed? _____

What concerns would you like to discuss with the doctor? _____

Medical History:

Please list active medical problems (e.g. diabetes, high blood pressure) and problems requiring diagnostic evaluation and tests in the past.

Please list dates of previous hospitalizations and surgeries, starting with most recent first.

Medications:

Do you have any allergies to medication or other substances? No _____ Yes _____

If yes, please state substance and reaction: _____

Please list all current medications:

Medication	Dose (mg)	How often?	Since when?

Please list any over the counter medications you take (including vitamins, laxatives, antacids): _____

Social History and Health Risks:

Marital Status: _____

Number of children: _____

Occupation: _____

Do you smoke? Yes_____ No_____ Quit_____

If yes, packs per day? _____

Do you drink alcohol? Yes_____ No_____

Number of drinks per week?

0-5_____ 5-10_____ 10-15_____ >15_____

Do you exercise? If yes, type and frequency:

_____

Are you exposed to sexual disease risks?

	No_____	Yes_____
Casual Sex?	No_____	Yes_____
Homosexual Partners?	No_____	Yes_____

Do you have a living will? _____

Family History:

Please check if your parent, brother, sister or child has had any of the following (indicate which family member).

Heart Disease: _____

Diabetes: _____

High Blood Pressure: _____

Colon Cancer/polyps: _____

Breast Cancer: _____

Other cancer: _____

Glaucoma: _____

Kidney or liver disease: _____

Other: _____

Health Maintenance Review:

Last eye exam: _____

Last cholesterol result: _____

Last Proctoscopy: _____

Last rectal exam: _____

Women:

Last Mammogram: _____

Last pelvic/Pap: _____

Any abnormal pap tests? _____

Immunizations:

Last Tetanus: _____

Last flu Vaccine: _____

Have you had the Pneumonia Vaccine? _____

TB skin test: _____

Have you had Chickenpox? _____

Personal Health Review:

General:

How do you judge your overall health? _____

Do you often worry about your health? _____

Weight loss more than 10 pounds this year?	No_____	Yes_____
Fever or chills?	No_____	Yes_____
Night sweats?	No_____	Yes_____
Dental/gum problems?	No_____	Yes_____

Skin:

Rashes or itching?	No_____	Yes_____

Comments/other _____

Ears:

Hearing problems?	No_____	Yes_____

Comments/other _____

Eyes:

Change in vision?	No_____	Yes_____
Contact Lenses?	No_____	Yes_____

Comments/other _____

Nasal Problems:

Chronic nose problems?	No_____	Yes_____
Hay fever?	No_____	Yes_____

Comments/other _____

Throat and Neck:

Hoarseness?	No_____	Yes_____
Lumps or Swelling?	No_____	Yes_____

Comments/other _____

Lungs:

Cough?	No_____	Yes_____
Wheezing?	No_____	Yes_____
Shortness of breath?	No_____	Yes_____
History of Tuberculosis?	No_____	Yes_____

Comments/other _____

Heart:

Chest pain or tightness? No_____ Yes_____
Skipped heart beats? No_____ Yes_____
Heart Murmur? No_____ Yes_____
High Blood Pressure? No_____ Yes_____
Trouble breathing/night? No_____ Yes_____
Leg swelling? No_____ Yes_____
History of Blood Clots? No_____ Yes_____
History/Rheumatic Fever? No_____ Yes_____
Comments/other _____

Stomach and Intestines:

Nausea, vomiting? No_____ Yes_____
Heartburn, indigestion? No_____ Yes_____
Abdominal pain? No_____ Yes_____
Constipation? No_____ Yes_____
Diarrhea? No_____ Yes_____
Bloody or black stool? No_____ Yes_____
History of Irritable Bowel? No_____ Yes_____
History of Liver Disease? No_____ Yes_____
Comments/other _____

Urinary Tract:

Excessive urination or urgency? No_____ Yes_____
Nighttime urination? No_____ Yes_____
Painful urination? No_____ Yes_____
Weak stream/Dribbling? No_____ Yes_____
Blood in urine? No_____ Yes_____
Urine leakage? No_____ Yes_____
Sexual concerns? No_____ Yes_____
History/prostate problems? No_____ Yes_____
Comments/other _____

Reproductive (women only):

Date of last menstrual period _____
Are periods regular? No_____ Yes_____
Age of onset of Menopause _____
Number of pregnancies _____
Number of children _____
Number of miscarriage(s) or abortion(s) _____
History of Breast Disease? No_____ Yes_____
If applicable, method of birth control _____
Comments/other _____

Muscle and Bone:

Painful or swollen joints? No_____ Yes_____
Back pain? No_____ Yes_____
History of Osteoporosis? No_____ Yes_____
History of Gout? No_____ Yes_____
Comments/other _____

Nervous System:

Headache? No_____ Yes_____
Dizziness? No_____ Yes_____
Fatigue? No_____ Yes_____
Depression? No_____ Yes_____
Anxious feelings? No_____ Yes_____
Comments/other _____

Blood and Metabolism:

Unusual hair growth? No_____ Yes_____
Heat or Cold Intolerance? No_____ Yes_____
Bleeding Problems? No_____ Yes_____
History/Thyroid disease? No_____ Yes_____
History of Anemia? No_____ Yes_____
Comments/other _____

Thank you for taking the time to complete this form.