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? ______________________

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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): ________________

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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_____
Sexual 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.