Medical History Questionnaire

Thank for choosing our group for your health care needs. Our physicians will be asking you about your present medical condition and problems. This information is essential in providing high quality medical care. Although some questions may be a little startling, please understand that they address current health issues. All information provided is strictly confidential and cannot be divulged to anyone without your permission.

Please use the bottom of the last page for additional information that does not fit in any section

Name: ____ Date:____________________
First Middle Initial Last

Date of Birth: _____/____/_____ Age:_________ Sex: M F Marital Status:____________

List all **Allergies** to medications: ____

Current Problems:

Briefly, what problems(s) has (or have) resulted in your visit today:____________________________

____

Past Medical History:

1. **(Females Only)**Total Pregnancies____ Deliveries____ Miscarriages____ Premature____ Live Births____ C-Section___ Normal Vaginal_____

2. List any **major injuries**, accidents or fractures:____________________________________

____

3. List any **surgical procedures** with dates if known:____________________________________

____

4. Have you ever had or been diagnosed with any of the following?

Crohn's disease	Yes ☐ No ☐	High Cholesterol	Yes ☐ No ☐	
Colon Polyps	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐	
Depression	Yes ☐ No ☐	Enlarged Prostate(**men**)	Yes ☐ No ☐	
Diabetes	Yes ☐ No ☐	Thyroid disease	Yes ☐ No ☐	Low ☐ or High ☐
Heart Attack	Yes ☐ No ☐	Ulcerative Colitis	Yes ☐ No ☐	
High Blood pressure	Yes ☐ No ☐			
Cancer	Yes ☐ No ☐	If yes Type: ____________________		

Any others not mentioned in this section? ____

5. When was your last Physical Exam (blood tests, EKGs, etc)? Date: ______/ ____/ ______

6. Have you ever had any of the following **screening exams**? (Try to put at least year if don't know date)

		(mm/yyyy)	*or-- How long ago?*
Cholesterol	Yes ☐ No ☐	Date of exam: _______/_____	___________
Colonoscopy	Yes ☐ No ☐	Date of exam: _______/_____	___________
Prostate (PSA-**Men**)	Yes ☐ No ☐	Date of exam: _______/_____	___________
DEXA/bone scan	Yes ☐ No ☐	Date of exam: _______/_____	___________
Fasting blood sugar	Yes ☐ No ☐	Date of exam: _______/_____	___________

CONTINUES ON BACK!!!

Females Only:

Pap Smear Yes ☐ No ☐ Date of exam: _______/_____ ___________

Mammogram Yes ☐ No ☐ Date of exam: _______/_____ ___________

7. List the date of your last **vaccination** if received (Try to put at least year if don't know date):

		(mm/yyyy)	*or-- How long ago?*
Hepatitis A	Yes ☐ No ☐	Date _____/______	__________
HPV/Gardisil (**females** only)	Yes ☐ No ☐	Date _____/______	__________
Meningococcal (Meningitis)	Yes ☐ No ☐	Date _____/______	__________
Pneumonia	Yes ☐ No ☐	Date _____/______	__________
Tetanus, diphtheria, pertussis (Tdap)	Yes ☐ No ☐	Date _____/______	__________
Tetanus-Diphtheria booster (Td)	Yes ☐ No ☐	Date _____/______	__________
Varicella	Yes ☐ No ☐	Date _____/______	__________

Family History

Have any of your close relatives (parents, siblings or children) had/have any of the following? (Check appropriate column) **For example**, if your father has depression do the following: Check the column with "F" in the row with Depression

F=Father Sib=sibling M=Mother	F	M	Sib	Child
Alcoholism				
Alzheimer's				
Asthma				
Breast Cancer				
Cervical Cancer (females)				
Colon Cancer				
Depression				
Diabetes				
Heart Attack				
High Blood pressure				

F=Father Sib=sibling M=Mother	F	M	Sib	Child
High cholesterol				
Mental Illness				
Osteoporosis				
Other Cancer				
Prostate Cancer (men)				
Thyroid disease				
Seizure Disorder				
Skin Cancer				
Stroke				
Sudden Death under age 60				

Medications

List all current medication and dosages:____

____

Social History

1. Do you Exercise regularly? Yes ☐ No ☐ Frequency? (x's per week) __________ Type____________
2. Do you smoke? Yes ☐ No ☐ How Long?______ If yes # packs per Day ______________________
3. Do you chew tobacco Yes ☐ No ☐ How Long?______
4. Do you drink Alcohol Yes ☐ No ☐ If yes, how often? Rarely Daily Weekly Monthly Socially

List any other questions or concerns you would like addressed at your appointment.

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