Patient Name:_____ Date of Birth:_____

Family History (A - Alive, D - Deceased)

	Age(s)	A / D	Medical Problems
Mother			
Father			
Brother(s)			
Sister(S)			
Children			

Check any of the following problems that you know run in your family:					
	Bypass Surgery		Strokes		High Blood Pressure
	Coronary (Blocked Arteries)Heart Disease		Bleeding disorder		Tuberculosis
	Congestive Heart Failure		Liver Disease		Migraine Headaches
	Diabetes		Kidney Disease		Too much Iron in blood
	Thyroid Disease		Decreased Memory		
	Cancer-List Type(s):				

If any of the above are checked, please provide details:_____
_____

List all the Medical Problems you have:_____
_____

List all of the Medications you take and the dosage, (include over the counter medication, vitamins, eyedrops, herbal supplements):

_____
_____
_____
_____
_____
_____

Operations you have had:
Cataract: ☐Left ☐ Right ☐Gallbladder Removed ☐Appendectomy ☐Hysterectomy ☐Other:
_____

Hospitalizations:_____
_____

Do you have an Advanced Directive (Living Will, Power of Attorney, or Do Not Resuscitate) ☐Yes ☐No
List any Occupational Illness, Injuries, or history of exposure to harmful Substances:

_____
_____

Health Habits:

	Past use only	Current use	Never	How long? How much?
Cigarettes				
Alcohol				
Drugs				
Chewing Tobacco				

Date of last Eye exam: _____

Have you ever had an Exercise Stress test? ☐ Yes ☐ No, If so what year_____

Have you ever had a Colonoscopy? ☐ Yes ☐ No, If so what year_____

Last Pneumonia Vaccine Date_____ Last Tetanus vaccine Date_____

Last Hepatitis Vaccine Date_____

Please list any specialists that you are seeing: _____

_____

_____

Please list any allergies that you have: _____

_____

Have you ever Donated Blood? ☐Yes ☐No If yes, what was the year of your last donation? _____

Have you ever been told you cannot give blood? ☐Yes ☐No If yes please provide details:

_____

Check all that apply and list details of checked items below:

☐ Headaches ☐ Skin disorder ☐ Pain in chest

☐ Weakness ☐ Ear pain

☐ Dizziness ☐ Stomach pains

_____

_____

_____

_____

Please list any other Medical history that you consider important to share:

_____

_____

_____

_____

_____

Medical History Questionnaire

Check Any that apply (please be patient and do not skip any)

☐Blood Transfusions
☐Head injury/ concussion
☐Fever/chills
☐ Night sweats
☐ Psoriasis
☐ Weight gain/loss
☐ Hernia
☐ Back Pain/ injury
☐ Epidural Steroid Shot
☐ Intolerant to heat/cold
☐ "Stretching" of esophagus
☐ Thyroid problems
☐ Hot Flashes
☐ Decreased hearing
☐ Ringing/ sound in ears
☐ Cataracts
☐ Vision problems
☐ Mouth sores
☐ Throat problems
☐ Loss of taste/smell
☐ Hoarseness
☐ Wheezing
☐ Exposure to TB
☐ Trouble breathing when laying flat
☐ Goiter
☐ Snoring
☐ Heartburn
☐ Trouble swallowing
☐ Dark/black stools
☐ Painful urination
☐ Frequent urination
☐ Getting up at night to urinate
☐ Slow stream/ dribbling
☐Leaking urine when coughing/lifting
☐ Glaucoma
☐ Eye injury
☐ Dental Problems
☐ Cold Sores
☐ Cough
☐ Short of breath
☐ Neck pain
☐ Leg swelling
☐ Gallstones
☐ Sleep Apnea
☐ Constipation
☐ Diarrhea
☐ Blood in urine
☐ Kidney stones
☐ Kidney infections
☐ Venereal Disease(Herpes, Syphilis)
☐ Trouble Sleeping
☐ Alcohol or Drug problems/addition
☐ Restless legs
☐ Nervousness/ Panic Attacks
☐ Diminished interest in sex
☐ Arthritis
☐ Lactose intolerant
☐ Tiredness/ Fatigue
☐ History of abnormal x-rays
☐ Falls
☐ Trouble walking
☐ HIV Positive
☐ AIDS
☐ Depressed/ low moods
☐ Daytime Sleepiness
☐ Burning/ numbness in legs
☐ Past treatment for nerves
☐ Suicidal thoughts/ attempts
☐ High Blood Pressure
☐ Bladder Catheter in past
☐ Gout
☐ Heart murmur
☐ Stomach ulcers
☐ Loss of appetite
☐ Pacemaker
☐ Hepatitis
☐ Anemia
☐ Nausea
☐ Seizures
☐ Helicobacter Pylori
☐ Macular Degeneration
☐ Rheumatoid Arthritis
☐ Broken bones
☐ Poor circulation
☐ Memory loss
☐ Low Testosterone levels
☐ Itching
☐ Shingles: Year _____

Heartbeat:
☐ Irregular ☐Fast ☐Slow ☐ Pounding

Men only:

☐ Prostate problems
☐ Problems with erections
☐ Prostate infections

Women only:

☐ Painful Menstrual Cycles
☐ Fertility problems
☐ Breast lumps/ discharge
☐ Irregular menstrual cycles
☐ Miscarriages/abortions
☐ Premenstrual syndrome
☐ History of abnormal Paps

Number of pregnancies: _____ Last Mammogram:_____ Last Pap Smear: _____