Medical History Questionnaire

Date: _____ Chart# _____

Patient Name_____ Birth date: _____

Name and address of physician referring you: _____

Do you presently have any problems in these areas? If yes, please explain:

Integument (skin)	Yes	No	_____
Head	Yes	No	_____
Eyes	Yes	No	_____
Ears, nose, mouth, throat	Yes	No	_____
Neck	Yes	No	_____
Bones, joints (arthritis)	Yes	No	_____
High Blood Pressure	Yes	No	_____
Kidney Disease	Yes	No	_____
Thyroid Disease	Yes	No	_____
Prostate Disease	Yes	No	_____
Respiratory (lungs, breathing, Asthma, Bronchitis)	Yes	No	_____
Cardiovascular (heart/blood vessels)	Yes	No	_____
Neurologic system (eg. Stroke)	Yes	No	_____
Lympharies (lymph nodes, swelling)	Yes	No	_____
Hematopoietic (blood)	Yes	No	_____
Allergic and immunologic	Yes	No	_____
Infectious (eg. Aids, Hepatitis)	Yes	No	_____
Psychiatric	Yes	No	_____
Diabetes	Yes	No	_____
Gastrointestinal (stomach, liver)	Yes	No	_____

List any medications you take: name, dosage, how many times a day. (Including Herbal and Over the counter meds)____

_____

_____

_____

_____

List any surgeries and hospitalizations you have had in the past: _____

_____

List any major illnesses and/or injuries you have had in the past: _____

_____

Do you have any allergies to any medications? Yes__ No __ If yes, please explain _____

_____

Are you allergic to latex? Yes__ No __ Are you allergic to tape? Yes__ No __

Are you allergic to shellfish, Iodine or Iodine preparations Yes__ No __

Any other allergies? _____

_____

Please explain _____

_____

_____

(over)

Family History:

What is the health status or cause of death of your parents, siblings or children? _____

_____

_____

Any diseases in the family? If yes, indicate relationship to patient:

Blindness	Yes	No	_____
Cataract	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Detachment	Yes	No	_____
Arthritis	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Attacks	Yes	No	_____
High Blood Pressure	Yes	No	_____
Kidney Disease	Yes	No	_____
Stroke	Yes	No	_____
Thyroid Disease	Yes	No	_____
Other	Yes	No	_____

Social History:

Present Occupation _____

Do you drink alcohol?	Yes	No	If yes, how many glasses a day? _____
Do you smoke?	Yes	No	If yes, how many packs a day? _____
Do you have an Advance Directive/Living Will?	Yes	No	

Symptoms: Do you:

Bleed excessively	Yes	No
Cough regularly	Yes	No
Have chest pain	Yes	No
Get short of breath	Yes	No
Sleep on more than one pillow	Yes	No
Have problems with urine	Yes	No
Have problems with digestion	Yes	No

FOR OFFICE USE:

History reviewed:

Physicians Signature: _____ Date: _____

Dates reviewed: _____

_____

_____

_____