MEDICAL HISTORY QUESTIONNAIRE: PLEASE ANSWER ALL QUESTIONS & PRINT LEGIBLY

NAME____DOB:_______________ AGE____________DATE______________________

WHY ARE YOU SEEING THE DOCTOR TODAY?____

WHEN DID SYMPTOMS START?____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OVER THE COUNTER OR HERBAL):

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO_______ YES ______ LIST____

CIRCLE IF YOU TAKE: ASPIRIN/BLOOD THINNER NASAL SPRAY INHALER FOR LUNGS BIRTH CONTROL PILLS

HAVE YOU EVER HAD SURGERY? NO______ YES______ LIST ____

ANY PROBLEMS WITH ANESTHESIA? NO______ YES______ LIST ____

ANY HOSPITALIZATIONS? NO______ YES______ LIST ____

DO YOU SMOKE OR USE CHEWING TOBACCO (CIRCLE WHICH)? NO_____ OR QUIT _____ (FILL) YEAR AGO
YES_____LIST PACKS____PER DAY; FOR _____ YEARS

DO YOU DRINK ALCOHOL? NO______ YES______ LIST NUMBER OF DRINKS ______ PER DAY

OCCUPATION: _____________________________________ ANY PETS INDOORS? NO______ YES______LIST________________________

FAMILY HISTORY: CIRCLE IF YOUR ***FAMILY*** HAS HAD ANY OF THE FOLLOWING ILLNESSES:

ALLERGY ASTHMA HEARING LOSS EAR TUBES HEAD/NECK CANCER THYROID PROBLEMS

DIABETES PROBLEMS WITH ANESTHESIA HIGH BLOOD PRESSURE HEART DISEASE FREE BLEEDING

PERSONAL HISTORY: CIRCLE IF ***YOU*** HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS:

1) GENERAL: WEIGHT LOSS APPETITE LOSS SNORING SLEEP APNEA

2) CVS: HEART ATTACK HEART MURMUR HIGH BLOOD PRESSURE HIGH CHOLESTEROL CHEST PAIN

3) PULMONARY: ASTHMA COPD SHORTNESS OF BREATH COUGH

4) GI: DIFFICULTY SWALLOWING INDIGESTION REFLUX/HEARTBURN STOMACH ULCER

5) CNS: STROKE DEVELOPMENTAL DELAY VERTIGO

6) ENDOCRINE: DIABETES THYROID PROBLEMS

7) HEMATOLOGY: BLOOD TRANSFUSIONS FREE BLEEDING IN SELF

8) SKIN: RASH ECZEMA FOOD ALLERGIES

9) INFECTIOUS: HEPATITIS HIV AIDS

10) EYES: ITCHY WATERY DRY VISION PROBLEMS

11) DENTAL: RECENT DENTAL WORK

PLEASE USE EXTRA SPACE TO EXPLAIN/ELABORATE MEDICAL HISTORY:____

____

REFERRING OR FAMILY PHYSICIANS NAME:____
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PHYSICIAN USE ONLY: I CERTIFIY THAT I HAVE REVIEWD THIS INFORMATION WITH THE PATIENT

____

SIGNED DATE