MEDICAL HISTORY QUESTIONNAIRE

NAME: ____ **DATE:**____________

Date of **Birth** ____________________ Date of **last physical exam**___________

Do you have allergies to any medications? **YES** **NO**
If YES, please list the medications:

____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): ____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.):

____

Do you ***currently*** have any problems in the following areas?:			
If YES, please provide information.	**YES**	**NO**	**Details**
Lungs			
Shortness of breath			
Chronic cough			
Wheezing			
Night time wheezing			
Chest pain			
Sinus drainage			
Seasonal allergies			
History of smoking			
Fatigue with activity			
Bloody sputum			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, chest pain, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea,constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			

	YES	NO	DETAILS
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia**)**			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (high cholesterol, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY M = Mother F = Father S = Sibling GP = Grandparent

Disease	YES	NO	Relationship to Patient
Gastrointestinal Disease			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Occupational history: ______________________

Education (high school, vocational school, college): ______________________

Number of people in your residence: ______________________

Do you drink alcohol? **YES** **NO** If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? **YES** **NO** If YES: occasional ½ pack/day 1 pack/day 1+ pack/day

Physician's Signature: ______________________ *Date:* ______________________