Medical History Questionnaire

Name:____________________________________ **Date of Birth**: _______________________________

List main reason for today's visit: ____

____

List any other active problems (include treating physician if applicable): ___________________________

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Allergies and reaction: ____

Medications and dosages (please include supplements): ______________________________________

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Do you feel you have problems with sleep, snoring or day time sleepiness?_____Yes_____No
Would you like to speak with us about this?_____Yes ____No

Past medical illnesses (Please place a check by all which applies):

___Alcohol/Drug Abuse	___Cancer	___Heart murmur	___STD(type)
___Anemia	___Crohn's disease	___Hepatitis B/C	___Sickle cell disease
___Aneurysm	___COPD/Emphysema	___High cholesterol	___Sleep apnea
___Anxiety disorder	___Depression	___HIV	___Stomach ulcer
___Arthritis	___Diabetes	___Hypertension	___Stroke
___Asthma	___Glaucoma	___Kidney disease	___Thyroid disease
___Blood disorder	___Gout	___Kidney stones	___Tuberculosis
___Blood clot	___Hay fever	___Liver disease	___Positive TB skin test
___Blood transfusion	___Heart disease	___Seizure	___Ulcerative colitis

___Other: (please specify) ____

Past Operations/Procedures and/or Hospitalizations (please include date): ________________________

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Family history (please indicate major medical problems; If deceased, please indicate cause of death):

Maternal Grandmother____

Maternal Grandfather____
Paternal Grandmother____
Paternal Grandfather____
Mother____

Father____
Siblings____
Children____

Social History

Occupation:___________________Marital Status:_________________Children: _____________________
Alcohol Use: Yes___No______ How often:____________________Quantity:_____________________
Tobacco Use: Yes___No_____ Pack per day:__________________How many Years: ______________
Former Smoker: Yes___No___ Pack per day:__________________Year quit: ____________________
Other Tobacco/Nicotine: Yes___No___Type:________________________Quantity:____________________
Other Drugs: Yes___No___If yes, please specify: ____
Exposure to asbestos or other hazardous material: Yes___No___If yes, please specify: __________________
Do you have a living will? Yes No__
Healthcare proxy: Yes___No___If yes, please indicate Name:___________Relationship: _________________

Health Maintenance

Last known Menstrual cycle:______________________Last known Pap Smear: _______________________
Last known Mammogram:________________________Last known Colonoscopy: _____________________
Last known Prostate Cancer Screening:_____________Last Bone Density scan: _______________________

Immunizations:

Pneumonia:_________________Flu:__________________________Tetanus/TD/Tdap:___________
Hepatitis A:_________________Hepatitis B: ________________

Review of Systems: (Please place a check by all which applies):

	Weight Gain		Weakness		Insomnia		Blood in vomit
	Persistent Cough		Fainting		Mood Swings		Bowel Changes
	Blood in Stool		Frequent urination		Difficulty swallowing		Runny nose
	Headache		Tremor		Nausea		Feeling cold
	Weight loss		Fatigue		Change in vision		Back pain
	Fever		Change in exercise Tolerance		Vaginal discharge/bleeding		
	Chest Comfort		Penis Discharge		Anxiety		Blood in sputum
	Difficult urinating		Breast pain		Change in hearing		Nipple discharge
	Memory Loss		Leg swelling		Depression		Short of breath
	Night Sweats		Pain with intercourse		Heartburn		Diarrhea
	Breast Lump		Trouble breathing		Skin rash		Nose bleed
	Leg pain		Palpitations		Feeling hot		Constipation
	Dizziness		Numbness/Tingling				

Patient Signature:____Date: ____________________________________

Reason Patient is Unable to Sign:____________________________Date:_____________________________________