PIEDMONT
INTERNAL
MEDICINE

# Medical History Questionnaire

**Name**: ___________________________________**Date of Birth**: ______________________________

**List main reason for today's visit:** _________________________________________________________

______________________________________________________________________________________

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

______________________________________________________________________________________

______________________________________________________________________________________

**Allergies and reaction:** _____________________________________________________________

**Medications and dosages** (please include supplements): _______________________________________

______________________________________________________________________________________

______________________________________________________________________________________

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

___Other: (please specify) ___________________________________________________________________

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

______________________________________________________________________________________

______________________________________________________________________________________

**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 | | Blood in vomit |
| | 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: ___________________________________