MEDICAL QUESTIONAIRE

NAME: _____ **BIRTHDATE:** _____

NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON UNLESS YOU HAVE AUTHORIZED US TO DO SO. **IF THE ANSWER TO ANY QUESTION IS UNKNOWN, LEAVE THE SPACE BLANK.**

PERSONAL HISTORY

HAVE YOU EVER HAD…?	YES	NO
TUBERCULOSIS	□	□
EMPHYSEMA	□	□
PNEUMONIA	□	□
CLOT IN THE LUNGS	□	□
ASTHMA OR BRONCHITIS	□	□
RHEUMATIC FEVER	□	□
HEART MURMUR	□	□
HEART ATTACK	□	□
HIGH BLOOD PRESSURE	□	□
MIGRAINE HEADACHES	□	□
SEIZURES OR EPILEPSY	□	□
STROKE	□	□
NEURITIS OR NEURALGIA	□	□
NERVOUS BREAKDOWN	□	□
PSYCHIATRIC ILLNESS	□	□
NEPHRITIS OR KIDNEY FAILURE	□	□

HAVE YOU EVER HAD…?	YES	NO
BLADDER TROUBLE	□	□
GONORRHEA, SYPHILIS, OR HERPES	□	□
DIABETES	□	□
HIGH CHOLESTEROL	□	□
THYROID DISEASE	□	□
ANEMIA OR BLOOD DISEASE	□	□
BLOOD TRANSFUSIONS	□	□
ULCERS OR COLITIS	□	□
JAUNDICE OR HEPATITIS	□	□
GALLBLADDER DISEASE	□	□
PANCREAS PROBLEMS	□	□
CANCER OR TUMOR	□	□
ARTHRITIS OR RHEUMATISM	□	□
MAJOR EYE PROBLEMS	□	□
SLEEP APNEA	□	□
SURGERY OF ANY KIND	□	□

	YES	NO
DO YOU HAVE ALLERGIES TO ANY MEDICATIONS?	□	□
DO YOU TAKE ANY MEDICATIONS, VITAMINS, SUPPLEMENTS, OR HERBAL THERAPY?	□	□
DO YOU DRINK ALCOHOL?	□	□
DO YOU CONSUME CAFFEINE?	□	□
DO YOU CHEW TOBACCO?	□	□
DO YOU NOW OR HAVE YOU EVER SMOKED? PACKS/DAY _____ YEARS _____	□	□

MEN ONLY	YES	NO
PROSTATE PROBLEMS?	□	□
WOMEN ONLY	YES	NO
MENSTRUAL PROBLEMS?	□	□
USING BIRTH CONTROL?	□	□
NUMBER OF PREGNANCIES		
NUMBER OF LIVE BIRTHS		
NUMBER OF STILL BIRTHS		
NUMBER OF MISCARRIAGES OR ABORTIONS		

WHEN WAS YOUR LAST…?

TETANUS VACCINE		SHINGLES VACCINE		COLONOSCOPY	
PNEUMONIA VACCINE		HEPATITIS A VACCINE		PSA (MEN ONLY)	
FLU VACCINE		HEPATITIS B VACCINE		MAMMOGRAM (WOMEN ONLY)	

FAMILY HISTORY

NUMBER OF: BROTHERS _____ SISTERS _____ CHILDREN _____

HAS ANY BLOOD RELATIVE EVER HAD:	YES	NO	WHO?
CANCER	□	□	
HEART TROUBLE	□	□	
STROKE	□	□	
DIABETES	□	□	
HIGH BLOOD PRESSURE	□	□	
ARTHRITIS	□	□	

REVIEW DO YOU NOW OR HAVE YOU HAD IN THE PAST YEAR…?

	YES	NO
FAINTING OR DIZZINESS	□	□
FREQUENT OR SEVERE HEADACHES	□	□
SUDDEN LOSS OF VISION	□	□
BLURRED OR DOUBLE VISION	□	□
EARACHES OR DISCHARGE	□	□
RECURRENT HEAD COLDS	□	□
HAY FEVER	□	□
PERSISTENT HOARSENESS	□	□
DIFFICULTY SWALLOWING	□	□
CHEST PAIN	□	□
NECK PAIN	□	□
ARM PAIN	□	□
ANKLE OR LEG SWELLING	□	□
COUGHING OF BLOOD	□	□
SHORTNESS OF BREATH WHEN:		
WALKING TWO BLOCKS	□	□
ONE FLIGHT OF STAIRS	□	□
LYING DOWN	□	□
CHRONIC OR FREQUENT COUGH	□	□
PURPLE LIPS OR FINGERS	□	□
HEART PALPITATIONS, SKIPPING, OR FLUTTERING	□	□
AWAKENING WITH SUDDEN SHORTNESS OF BREATH	□	□
SWOLLEN GLANDS	□	□
NIGHT SWEATS	□	□
SEVERE SNORING	□	□
MAJOR SLEEP PROBLEMS	□	□
	□	□

	YES	NO
WEIGHT LOSS OR GAIN	□	□
LOSS OF APPETITE	□	□
CHANGE IN SKIN TEXTURE	□	□
CHANGE IN HAIR TEXTURE	□	□
INABILITY TO STAND COLD	□	□
INABILITY TO STAND HEAT	□	□
CHANGE IN A MOLE	□	□
CHANGE IN SKIN COLOR	□	□
RECURRENT STOMACH PAIN	□	□
HEARTBURN	□	□
PERSISTANT NAUSEA OR VOMITING	□	□
BLOOD IN BOWEL MOVEMENT	□	□
TARRY COLORED BOWEL MOVEMENT	□	□
FREQUENT DIARRHEA	□	□
SEVERE CONSTIPATION	□	□
CHANGES IN URINATION	□	□
DIFFICULTY WITH URINATION	□	□
BLOOD IN URINE	□	□
FREQUENT NIGHTTIME URINATION	□	□
JOINT SWELLING	□	□
JOINT PAIN	□	□
TINGLING OR NUMBNESS IN HANDS OR FEET	□	□
SUDDEN TREMBLING IN HANDS OR FEET	□	□
MEMORY CONCERNS	□	□
LUMPS UNDER SKIN	□	□
SEVERE DEPRESSION	□	□
SEXUAL DIFFICULTIES	□	□