Medical History Questionnaire

Name_____ Today's Date: ____/____/_____

Address_____Phone:_____

_____Work Phone:_____

Birth Date: ___/___/_____ Age: ____ Social Security: ____/___/_____ Marital Status: _____

Occupation:_____Employer:_____ E-mail:_____

Person Responsible for Bill:_____ Referred by:_____

Name of Medical Doctor: _____ Dr's Phone: _____ Last Medical Exam: _____

IF Applicable, are you pregnant and/or nursing: __ Do you have allergies to medications? ____No ____Yes, if Yes, explain:

_____

List any medications you take **and what they are for** (including oral contraceptives, aspirin, over the counter medications and home remedies:

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever,Weight Loss/Gain	___	___	___
INTERGUMENTARY(SKIN)	___	___	___
NEUROLOGICAL			
Headaches	___	___	___
Migraines	___	___	___
Seizures	___	___	___
ENDOCRINE			
Thyroid/Other Glands	___	___	___
GASTROINTESTINAL			
Diarrhea	___	___	___
Constipation	___	___	___
GENITOURINARY			
Genitals/Kidney/Bladder	___	___	___
Anemia	___	___	___
LYMPHATIC/HEMATOLOGIC			
Bleeding Problems	___	___	___
VASCULAR/CARDIOVASCULAR			
Diabetes	___	___	___
Heart Pain	___	___	___
High Blood Pressure	___	___	___
Vascular Disease	___	___	___

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	___	___	___
Sinus Congestion	___	___	___
Runny Nose	___	___	___
Post-Nasal Drip	___	___	___
Chronic Cough	___	___	___
Dry Throat/Mouth	___	___	___
RESPIRATORY			
Asthma	___	___	___
Chronic Bronchitis	___	___	___
Emphysema	___	___	___
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	___	___	___
Muscle Pain	___	___	___
Joint Pain	___	___	___
PSYCHIATRIC	___	___	___
ALLERGIC/IMMUNOLOGIC	___	___	___

SOCIAL HISTORY

Do you use tobacco products? ___ ___
Type/Amount_____

Do you drink alcohol ___ ___
Type/Amount_____

Do you use illegal drugs ___ ___
Type/Amount_____

HEIGHT: FLU SHOT?: B.P._____

WEIGHT: PNEUMONIA SHOT (over 65):

Have you ever been exposed to or infected with: Gonorrhea ____ Hepatitis____ HIV___ Syphilis ____

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer _____Yes, I would.