Patient Health & Medical History Questionnaire

Date: _____

First Name: _____ Age: _____

Middle Name: _____ Ethnicity/Race: _____

Last Name: _____ Marital Status: _____

Sex: ☐ Male ☐ Female

Please answer carefully the enclosed questionnaire about your present and past medical problems and the history of your current illness. It is important that you complete each of the questions as accurately as possible so the doctor can best understand the nature of your present medical problems.

This information will become part of your permanent record and will remain confidential. The contents of this questionnaire will only be released with your written authorization.

List Your Physician(s)

Use additional pages if needed. Check box if provider is to receive a copy of today's consultation.

☐ Personal Physician: _____ Phone: _____

☐ Surgeon: _____ Phone: _____

☐ Cardiologist: _____ Phone: _____

☐ Pulmonologist: _____ Phone: _____

☐ Urologist: _____ Phone: _____

☐ Gastroenterologist: _____ Phone: _____

☐ Other: _____ Phone: _____

Your Pharmacy

Name: _____ Phone: _____

History of Present Illness

Physician Comments

What is the reason for your visit? _____

_____

_____

_____

What are your current symptoms and how long have you had them? _____

_____

_____

_____

Have you received treatment for this diagnosis?

☐ No ☐ Yes. Please give date and location of the treatment/surgery:

Surgery: _____

Radiation: _____

Drug or other therapy (chemotherapy): _____

Do you have other medical problems that are now being treated?

☐ No ☐ Yes. Please list them here:

_____

_____

_____

Past Medical History

Check the illnesses that you have had or currently have. Provide the year for those that required hospitalization:

☐ Heart Disease _____	☐ Scarlet Fever _____	☐ Kidney Disease _____
☐ Cancer _____	☐ Hepatitis _____	☐ Bronchitis *(Recurring)* _____
☐ Diabetes _____	☐ Stomach Ulcer _____	☐ Venereal Disease _____
☐ Emphysema _____	☐ Liver Disease _____	☐ Nervous Breakdown _____
☐ Hives _____	☐ Jaundice _____	☐ Bleeding Disorder _____
☐ Asthma _____	☐ Measles _____	☐ Rheumatic Fever _____
☐ Tuberculosis _____	☐ Mumps _____	☐ High Blood Pressure _____
☐ Valley Fever _____	☐ Chicken Pox _____	☐ Shingles _____
☐ Blood Clots _____	☐ Anemia _____	☐ Herpes Zoster _____
☐ Seizures _____	☐ Pneumonia *(Recurring)* _____	☐ Thyroid Disease _____

Other serious illness: _____

Have you had any of the surgeries listed below? Check and give the year:

☐ Appendix _____	☐ Stomach _____	☐ Bladder _____
☐ Breast _____	☐ Artery _____	☐ Heart Problems _____
☐ Eyes _____	☐ Colon _____	☐ Heart Surgery _____

Past Medical History *(cont.)*

Physician Comments

Have you had any of the surgeries listed below? Check and give the year:

☐ Hip _____	☐ Gallbladder _____	☐ Hernia Repair _____
☐ Lung _____	☐ Knee _____	☐ Prostate Gland _____
☐ Ovary _____	☐ Mastoids _____	☐ Thyroid Gland _____
☐ Kidney _____	☐ Nose _____	☐ Hemorrhoids _____
☐ Veins _____	☐ Tubes Tied _____	☐ Tonsil & Adenoids _____
☐ Bone Marrow _____	☐ Uterus _____	☐ Dilatation & Curettage _____

Other surgeries: _____

_____

Have you ever had problems with anesthesia?

☐ No ☐ Yes: Please state the problem: _____

Have you ever had radiation treatment?

☐ No ☐ Yes: What part(s) of the body: _____

Have you ever had serious accidents or injuries?

☐ No ☐ Yes: Please describe: _____

Have you ever had blood transfusions?

☐ No ☐ Yes: List how many: _____

Medications

List the names of any medications that you take regularly:

Name:	Dose:	Frequency:	Date Started:

Would you like to have some of your prescriptions filled at our office? ☐ No ☐ Yes

Vaccination Information

Flu Shot

Date Taken: _____ Location: ☐ Left Arm ☐ Right Arm

Covid-19

1st Dose: _____ Location: ☐ Left Arm ☐ Right Arm

2nd Dose: _____ Location: ☐ Left Arm ☐ Right Arm

Booster: _____ Location: ☐ Left Arm ☐ Right Arm

Manufacturer: ☐ Moderna ☐ Pfizer ☐ Johnson & Johnson

Allergies

Physician Comments

Medication/Food:	Reaction:	Date First Occurred:

Personal Habits

List the jobs you have held: _____

_____

_____

Have you ever been exposed to any of the following?

Radiation ☐ No ☐ Yes
Petroleum Products ☐ No ☐ Yes
Industrial Toxins ☐ No ☐ Yes
Insecticides ☐ No ☐ Yes
Benzene ☐ No ☐ Yes

Smoking:

☐ Yes, current every day smoker. Number of years: _____ Packs per day: _____
☐ Yes, occasional smoker. Number of years: _____ Packs per week: _____
☐ Previously smoked, but quit. Years quit: _____
☐ Never smoked

Do you drink alcohol? ☐ No ☐ Yes: List amount & type: _____
Have you been on a diet in the past? ☐ No ☐ Yes: List type and reason: _____
Have you ever used "street drugs" (cocaine, marijuana, LSD, etc.)? ☐ No ☐ Yes

Religious Beliefs *(optional)*

Do you have a religious background? ☐ No ☐ Yes: Explain: _____
Will your religious beliefs have an important role in your treatment? ☐ No ☐ Yes
Would you like a doctor, nurse or other staff member to pray with you? ☐ No ☐ Yes

Cancer Screening

Have you had any of the following tests? If yes, when and where?

Mammogram ☐ No ☐ Yes When: _____ Where: _____
Pap Smear ☐ No ☐ Yes When: _____ Where: _____
Prostate Exam ☐ No ☐ Yes When: _____ Where: _____
PSA ☐ No ☐ Yes When: _____ Where: _____
Colon Exam ☐ No ☐ Yes When: _____ Where: _____
Skin Exam ☐ No ☐ Yes When: _____ Where: _____
Chest X-Ray ☐ No ☐ Yes When: _____ Where: _____
Other: _____ When: _____ Where: _____

General Health Family History

Physician Comments

List the members of your immediate family, their ages, current health status and if deceased, their age of death.

	Age	Health Status			Cause of Death & Age
		Good	Fair	Poor	
Mother		☐	☐	☐	
Father		☐	☐	☐	
Sister(s)		☐	☐	☐	
Brother(s)		☐	☐	☐	
Daughter(s)		☐	☐	☐	
Son(s)		☐	☐	☐	

List others here: _____

_____

_____

_____

_____

Are you of Ashkenazi Jewish heritage? ☐ No ☐ Yes

Has any family member had a blood disease?

☐ No ☐ Yes: List relationship and type of blood disease: _____

_____

_____

Do you have any birth defects in your family history?

☐ No ☐ Yes: Please explain: _____

_____

_____

Are you a twin? ☐ No ☐ Yes

Were you born with a birth defect?

☐ No ☐ Yes: Please explain: _____

_____

_____

Cancer Family History

Physician Comments

Write in the ***age*** of each cancer diagnosis in the box below for yourself and each family member who has been diagnosed with cancer as indicated.

	Breast Cancer	Male Breast Cancer	Colon Cancer	Prostate Cancer	Pancreatic Cancer	Endometrial Cancer	Ovarian Cancer	Other *Fill in cancer type & age diagnosed.*
Yourself	☐	☐	☐	☐	☐	☐	☐	
Mother	☐		☐	☐	☐	☐	☐	
Father		☐	☐	☐	☐	☐		
Sister(s)	☐		☐	☐	☐	☐	☐	
Brother(s)		☐	☐	☐	☐	☐		
Daughter(s)	☐		☐	☐	☐	☐	☐	
Son(s)		☐	☐	☐	☐	☐		
MOTHER'S SIDE								
Grandmother	☐		☐	☐	☐	☐	☐	
Grandfather		☐	☐	☐	☐	☐		
Aunt(s)	☐		☐	☐	☐	☐	☐	
Uncle(s)		☐	☐	☐	☐	☐		
Cousin(s)	☐	☐	☐	☐	☐	☐	☐	
FATHER'S SIDE								
Grandmother	☐		☐	☐	☐	☐	☐	
Grandfather		☐	☐	☐	☐	☐		
Aunt(s)	☐		☐	☐	☐	☐	☐	
Uncle(s)		☐	☐	☐	☐	☐		
Cousin(s)	☐	☐	☐	☐	☐	☐	☐	

☐ Family history unknown.

Review of Systems

Physician Comments

Do you have, or have you had ***in the last 6 months***, any of the following?

General weakness	☐ No ☐ Yes
Skin rashes	☐ No ☐ Yes
Change in taste	☐ No ☐ Yes
Sores not healing	☐ No ☐ Yes
Fever of unknown cause	☐ No ☐ Yes
Weight loss without cause	☐ No ☐ Yes
Enlarging moles	☐ No ☐ Yes
Night sweats	☐ No ☐ Yes
Chills	☐ No ☐ Yes
Loss of appetite	☐ No ☐ Yes
Do you have frequent/recurring headaches?	☐ No ☐ Yes
Do you have frequent dizzy spells?	☐ No ☐ Yes
Have you ever fainted?	☐ No ☐ Yes
Have you had a recent change in eyesight?	☐ No ☐ Yes
Have you had a recent change in hearing?	☐ No ☐ Yes
Do you have ringing or roaring in your ears?	☐ No ☐ Yes
Do you wear dentures?	☐ No ☐ Yes
Do they fit properly?	☐ No ☐ Yes
Do you have frequent soar throats?	☐ No ☐ Yes
Do you have trouble swallowing?	☐ No ☐ Yes
Do you have hoarseness without colds?	☐ No ☐ Yes
Have you lumps or swelling in the neck?	☐ No ☐ Yes
Do you cough up a lot of phlegm?	☐ No ☐ Yes
Have you coughed up blood?	☐ No ☐ Yes
Do you have coughing spells?	☐ No ☐ Yes
Do you have shortness of breath without exercise?	☐ No ☐ Yes
Do you have shortness of breath with exercise?	☐ No ☐ Yes
Have you had pains in your chest?	☐ No ☐ Yes
Have you been treated for heart problems?	☐ No ☐ Yes
Have you had high blood pressure?	☐ No ☐ Yes
Have you had thumping or racing heart?	☐ No ☐ Yes
Do your ankles swell?	☐ No ☐ Yes
Do you have frequent indigestion?	☐ No ☐ Yes
Do you have pain in your stomach?	☐ No ☐ Yes
Have you had frequent nausea or vomiting?	☐ No ☐ Yes
Have you ever vomited blood?	☐ No ☐ Yes
Have you had black bowel movements?	☐ No ☐ Yes

Review of Systems *(cont.)*

Physician Comments

Do you ***currently*** have any of the following?

Have your bowel movements changed in the last 6 months?	☐ No ☐ Yes
Have you had blood in your bowel movements?	☐ No ☐ Yes
Do you notice burning on urination?	☐ No ☐ Yes
Do you get up every night to urinate?	☐ No ☐ Yes
Have you passed blood in urine?	☐ No ☐ Yes
Have you passed a kidney stone?	☐ No ☐ Yes
Have you had root beer colored urine?	☐ No ☐ Yes
Any change in your desire for sexual activity?	☐ No ☐ Yes
Any change in your ability to engage in sexual activity?	☐ No ☐ Yes
Do you have joint trouble?	☐ No ☐ Yes
Do you have constant back pain?	☐ No ☐ Yes
Do you have constant bone pain?	☐ No ☐ Yes
Do your bruise easily?	☐ No ☐ Yes
Do you bleed easily?	☐ No ☐ Yes
Do your gums bleed frequently?	☐ No ☐ Yes
Do you have prolonged bleeding with cuts?	☐ No ☐ Yes
Do you have frequent nosebleeds?	☐ No ☐ Yes
Do you have feelings of sadness, depression or anxiety?	☐ No ☐ Yes

FOR MEN ONLY

Do you have trouble urinating?	☐ No ☐ Yes
Have you been told you have prostate problems?	☐ No ☐ Yes
Have you been circumcised?	☐ No ☐ Yes

Breast Health History *(Women Only)*

Do you conduct breast self exams?	☐ No ☐ Yes
Do you feel palpable lumps?	☐ No ☐ Right ☐ Left ☐ Both
Do you have nipple discharge?	☐ No ☐ Right ☐ Left ☐ Both
Do you have nipple inversion?	☐ No ☐ Right ☐ Left ☐ Both
Has the size or shape of the nipples changed?	☐ No ☐ Right ☐ Left ☐ Both
Have you had any breast trauma?	☐ No ☐ Right ☐ Left ☐ Both
Have you had any breast cyst aspirated?	☐ No ☐ Right ☐ Left ☐ Both
Do you feel breast pain?	☐ No ☐ Right ☐ Left ☐ Both
If yes, is the pain related to periods?	☐ No ☐ Yes
Have you had any prior breast surgery?	☐ No ☐ Yes

Type of surgery: ☐ Biopsy ☐ Lumpectomy ☐ Mastectomy

If yes, check which side and list diagnosis year and where the surgery was preformed:

☐ Left Diagnosis, list year: _____, where: _____

☐ Right Diagnosis, list year: _____, where: _____

Gynecologic History *(Women Only)*

Physician Comments

Have you ever taken hormones? ☐ No ☐ Yes

If yes, give type: _____ Duration: _____ Stopped: _____

Have you ever taken birth control pills? ☐ No ☐ Yes

If yes, when were they started? _____ When were they stopped? _____

How old were you when you began menstruating? _____

Do you bleed between your periods? ☐ No ☐ Yes

Do you still have periods?

☐ Yes, indicate date of first day of last period: _____

☐ No, check reason: ☐ Natural, at what age? _____ ☐ Surgery, at what age? _____

Are you currently pregnant? ☐ No ☐ Yes

Are you interested in having more children? ☐ No ☐ Yes

Age when you first became pregnant with your first full-term pregnancy? _____

Have you had any complications of pregnancy? ☐ No ☐ Yes, describe: _____

_____

_____

_____

Did you breast feed? ☐ No ☐ Yes, for _____ months.

Please indicate the following:

Number of pregnancies: _____ Number of premature births: _____

Number of cesareans: _____ Number of abortions: _____

Number of miscarriages: _____ Number of children born alive: _____

Number of stillborn: _____