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 records 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. Provide the year for those needing 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 a blood transfusion?

☐ No ☐ Yes: Month: ______ Year: ______

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

Allergies

Medication/Food:	Reaction:	Date First Occurred:

Personal Habits

Physician Comments

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

Where 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.

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Review of Systems

Physician Comments

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

Question	Response
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 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 cesareans: ____________

Number of miscarriages: ____________

Number of stillborn: ____________

Number of premature births: ____________

Number of abortions: ____________

Number of children born alive: ____________