# 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

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: _____