MEDICAL HEALTH QUESTIONNAIRE

NAME:______________________________ AGE: _____

Date of Birth:_________________________ Height: ____________

REFERRING PHYSICIAN ______________________________ Weight: ____________

PRIMARY PHYSICIAN ______________________________

HOME PHONE: ( ) _______________ WORK PHONE: ( ) ____________

CELL PHONE: ( ) _______________

REASON FOR VISIT: ____

____

*Please check **ALL** that apply to you:*

PAST MEDICAL HISTORY:

- [ ] high blood pressure
- [ ] high cholesterol
- [ ] diabetes
- [ ] cancer
- [ ] blood clots
- [ ] heart disease *(please specify)*
- [ ] asthma
- [ ] emphysema
- [ ] hypothyroidism
- [ ] hyperthyroidism
- [ ] liver disease
- [ ] kidney disease
- [ ] stroke
- [ ] acid reflux
- [ ] depression
- [ ] anxiety
- [ ] other: *(please specify)*

PAST SURGICAL HISTORY:

- [ ] appendectomy
- [ ] gall bladder
- [ ] hysterectomy
- [ ] ovaries removed
- [ ] other: *(specify)* ____________________ ____________________
- [ ] hernia repair
- [ ] prostate surgery
- [ ] colon surgery
- [ ] breast surgery
- [ ] vascular bypass
- [ ] heart surgery
- [ ] heart stenting

CURRENT MEDICATION LIST: ***PHARMACY:*** ____________________

1 ____________________ 4 ________________ 7 ____________________

2 ____________________ 5 ________________ 8 ____________________

3 ____________________ 6 ________________ 9 ____________________

Are you currently taking any of the following blood thinners?

- [ ] Aspirin
- [ ] Coumadin
- [ ] Plavix

ALLERGIES:

1 ____________________ 4 ________________

2 ____________________ 5 ________________

3 ____________________ 6 ________________

FAMILY HISTORY: *If any of the follow are checked please answer question following.*

- [ ] Breast cancer Relationship____________ Age diagnosed___________
- [ ] Ovarian cancer Relationship____________ Age diagnosed___________
- [ ] Colon cancer Relationship____________ Age diagnosed___________
- [ ] Other cancer Relationship____________ Age diagnosed___________
- [ ] Heart disease
- [ ] Diabetes
- [ ] Blood clots
- [ ] Bleeding disorders
- [ ] other: *(specify)* ____________________ ____________________

(TURN OVER)

Name:______________
Date Of Birth:________

SOCIAL HISTORY:

Do you use **tobacco** products? Yes or No   Amount______ Years________
If Yes are you interested in cessation program? Yes or No
Do you drink **alcohol**? Yes or No # ______per week
Occupation ___________________________   Require heavy lifting? _____________
Interests/hobbies ____

REVIEW OF SYSTEMS: *(Please check all that apply)*

General

☐ Weight changes ☐ Chills ☐ Hot flashes
☐ Fevers ☐ Night sweats

Head/Ears/Eyes/Nose/Throat

☐ Visual changes ☐ Hoarseness ☐ Difficulty Swallowing

Respiratory (lungs)

☐ Cough ☐ Wheezing ☐ Difficulty Breathing

Cardiovascular (heart)

☐ Chest pain ☐ Leg swelling ☐ Resting leg pain
☐ Palpitations ☐ Varicose veins ☐ Leg cramping

Gastrointestinal (stomach/intestines)

☐ Heartburn ☐ Diarrhea ☐ Change in color of skin
☐ Nausea/Vomiting ☐ Constipation ☐ Fecal incontinence
☐ Abdominal pain ☐ Rectal bleeding ☐ Date of Last Colonoscopy_______

Urinary System

☐ Urinary Incontinence ☐ Frequency ☐ Burning with urination
☐ Change in stream ☐ Blood in urine ☐ Dialysis

Musculoskelatal

☐ Difficulty walking ☐ Back/Joint pain ☐ Exercise routinely

Neurological

☐ Headaches ☐ Dizziness ☐ Anxiety
☐ Paralysis

Skin

☐ Nonhealing sores ☐ Rash ☐ Abnormal moles
☐ Lumps

Gynecological

☐ Breast lumps/mass ☐ Breast pain
☐ Nipple discharge ☐ Skin changes

Age of first menstrual cycle? ______________________________
First day of last menses? ________________________________
Age at menopause ______________________________
☐ Hormone replacement therapy__________ ☐ Currently taking?
if answered yes~ Length of time on hormone therapy? ____________________
Number of pregnancies______________________ Number of children ____________
Age of first live birth ______________________
Date of last pelvic exam ___________________ Doctor ____________________
Date of last mammogram ___________________

Reviewed by:
Date: