

# Patient Medical History Questionnaire

REV 5.10



84 MARGINAL WAY

SUITE 985

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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

1. In a few words, please describe your medical problem: \_\_\_\_\_

2. How long have you had this problem? \_\_\_\_\_

3. Check off any of the following conditions you are currently experiencing or have experienced in the past: NONE

Head, Eyes, Ears, Nose, Throat

NONE

- Glaucoma
- Double Vision
- Dizzy Spells
- Severe Headache
- Ringing in Ears
- Nose Bleeds
- Difficulty Swallowing
- Cataracts
- Blindness
- Fainting Spells
- Seizures
- Deafness
- Sores in Mouth
- Hearing Loss
- Vision Loss

Gastrointestinal

NONE

- Weight Loss
- Weight gain
- Chronic Heartburn
- Liver Disease
- Yellow Jaundice
- Constipation
- Nausea
- Vomiting
- Ulcers
- Cirrhosis
- Irregular Bowels
- Bloody Stools
- Diarrhea
- Hepatitis
- Abdominal Pain

Genito-urinary

NONE

- Bloody Urine
- Venereal Disease
- Bladder Infections
- Kidney Disease
- Frequent Urination
- Painful Urination
- Loss of urine when sneezing/coughing

Coagulation

NONE

- Frequent Bruising
- Abnormal Clotting
- Abnormal Bleeding
- Bleeding after other operations

Cardiovascular / Respiratory

NONE

- Heart Failure
- Heart Attack
- Heart Murmur
- Chest Pain
- Persistent swelling in ankles
- High Blood Pressure
- Asthma
- Emphysema
- Chronic Cough
- Coughing up blood
- Shortness of breath on exertion

Endocrine

NONE

- Diabetes
- Excessive Thirst
- Thyroid
- Gout
- Rheumatism
- Arthritis
- Growth Problems
- Sensitive to hot or cold environment
- Unusual recent change in appearance
- Recent swelling in hands and feet
- Broken Bones

Neurologic

NONE

- Headache
- Weakness
- Stroke
- Tremors
- Seizures
- Loss of Coordination
- Tingling/Numbness
- Fainting Spells
- Speech Changes
- Functional Changes
- Confusion
- Nerve Disorder or "Nerve Troubles"

4. What is the health status of your family?

Father:  Living  Deceased If deceased, cause of death: \_\_\_\_\_

Mother:  Living  Deceased If deceased, cause of death: \_\_\_\_\_

Siblings: Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ Number Living \_\_\_\_\_

If deceased, cause of death: \_\_\_\_\_

Please check off any family history of the following conditions:

- Tuberculosis
- Cancer
- Gout
- Diabetes
- Bleeding Disorders
- Rheumatic Fever
- Heart Murmur
- Other: \_\_\_\_\_

5. What is your social history?

Marital Status:  Married  Single  Divorced  Widow/Widower

Present Occupation \_\_\_\_\_

Number of living children \_\_\_\_\_ Number of people in household \_\_\_\_\_

Do you use tobacco?  Yes  No If yes, amount per day \_\_\_\_\_

Do you drink alcoholic beverages (beer, liquor, etc.)?  Yes  No If yes, number of drinks per day: \_\_\_\_\_

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