MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME:________________________________ DATE:______________________________

DATE OF BIRTH: ______________________________ SOCIAL SECURTIY NUMBER_______________

Marital Status:(**circle one**) Single Married Divorced Widowed

LIST OF PRESENT COMPLAINTS:

1. ____
2. ____

Were other doctors consulted for this condition? ☐ Yes ☐ No **If yes, please list below:**

1. _________________________________ Diagnosis_________________________________
2. _________________________________ Diagnosis_________________________________

Have you had any recent X-rays, CT's, or MRI's pertaining to this condition? ☐ Yes ☐ No **If yes, list where taken**

____

Have you had any broken bones or dislocations? ☐ Yes ☐ No Describe______________________________

List surgeries you have had: ____

Have you ever been knocked unconscious? ☐ Yes ☐ No When? ______________________________

List serious accidents or falls: ____

____

Have you ever been in an auto accident? ☐ Yes ☐ No If yes, when______________________________

***LIST OF ALL MEDICATIONS AND DOSAGES: (USE BACK OF PAGE IF NECESSARY)_

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****MEDICATION ALLERGIES:____

*****Smoking Status:(**Must Select One**) Current every day smoker / Current Some Day Smoker / Former Smoker/ Never Smoked / Smoker- Current status Unknown

(PLEASE COMPLETE BACK SIDE)

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?	YES	NO	DETAILS (please list or circle any medical condition)
GENERAL/CONSTITUTIONAL (fever, weight loss, weight gain, fatigue, cancer)			
EARS (ear ache)			
NOSE (stuffy nose)			
THROAT (dry mouth)			
CARDIOVASCULAR (high BP, congestive heart failure, chest pain, heart attack, carotid disease, irregular heartbeat, etc.)			
RESPIRATORY (wheezing, asthma, emphysema, coughing, bronchitis, TB, shortness of breath, etc.)			
GASTROINTESTIONAL (stomach ulcers, intestinal disease, ulcerative colitis, Crohn's, diarrhea, etc.)			
FEMALES: Are you Pregnant? Nursing?			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, kidney stones, kidney failure, etc.)			
MUSCLES, BONES, JOINTS (Musculoskeletal) (joint pain, stiffness, swelling, osteoarthritis, rheumatoid arthritis, fibromyalgia, gout, etc.)			
SKIN (pimples, warts, growths, rash, eczema, seborrhea, psoriasis, etc.)			
NEUROLOGICAL (numbness, headache, stroke, seizures, multiple sclerosis, myasthenia gravis, migraines, etc.)			
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, seasonal allergies, etc.)			
BLOOD / LYMPH (bleeding problems, anemia, sickle cell, high cholesterol, HIV/AIDS, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, claustrophobia, etc.)			

Height:__________ Weight:_________________ Blood Pressure:_____________

HAS ANY MEMBER OF YOUR FAMILY HAD THESE DISEASES? (Mother, Father, Grandparents, Sibling)				
FAMILY HISTORY	**YES**	**NO**	**UNKNOWN**	**DETAILS**
Diabetes				
Hypertension				
Heart Disease				
Stroke				
Cancer				
Thyroid Disease				
Arthritis				
Multiple Sclerosis				
Other (Explain)				
Family History Unknown				

Patient/ Legal Guardian Signature____Date__________________