MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____

Primary Doctor _____ Today's Date _____

What Condition are you being seen for today ?

_____

_____

_____

_____

Please list all the medications you take. Include all vitamins and other over-the-counter medications. (Example: aspirin, 325 mg, one a day)

_____

_____

_____

_____

Please list any Allergies

_____

_____

_____

Have you had any x-rays or procedures done in the past 3 months where you were given contrast/dye?

_____

_____

Do you have, or have you had, any of the following medical conditions?

	Yes	
Eye disease	☐	_____
Pituitary problems	☐	_____
Thyroid problems	☐	_____
Head/neck irradiation	☐	_____
Diabetes	☐	_____
Heart problems	☐	_____
Cholesterol problems	☐	_____
High blood pressure	☐	_____
Stroke	☐	_____
Lung problems	☐	_____
Bowel disease	☐	_____
Heartburn/Reflux Gallstones	☐	_____

(continued on back)

	Yes	
Kidney problems/	☐	
Stones adrenal problems	☐	
Arthritis	☐	
Tuberculosis	☐	
Cancer	☐	
Anemia (low blood count)	☐	
Skin disorders	☐	

Surgeries Please List All Below

Do your family members have, or have they had, any of the following medical conditions?
(parents, siblings, children)

	Yes	**Relationship to patient**
Eye disease	☐	
Pituitary problems	☐	
Thyroid problems	☐	
Diabetes	☐	
Heart problems	☐	
Cholesterol problems	☐	
High blood pressure	☐	
Stroke	☐	
Lung problems	☐	
Bowel disease	☐	
Kidney problems/stones	☐	
Adrenal problems	☐	
Arthritis	☐	
Tuberculosis	☐	
Cancer	☐	
Anemia (low blood count)	☐	
Skin disorders	☐	
Other	☐	

(continued on next page)

Name: _____

What is your occupation? _____

How much alcohol do you drink? _____

How much do or did you smoke? Currently _____
Past _____

How many children do you have? _____

Do you <u>currently</u> have any of the following complaints?

	Yes	
Change in appetite	☐	
Change in weight	☐	
Fever	☐	
Chills	☐	
Night sweats	☐	
Change in energy	☐	
Headaches	☐	
Blurry vision	☐	
Double vision	☐	
Loss of vision	☐	
Other change in eyes	☐	
Congestion	☐	
Sore throat	☐	
Lesions in mouth	☐	
Difficulty swallowing	☐	
Hoarseness/change in voice	☐	
Cough	☐	
Shortness of breath	☐	
Chest pain	☐	
Fast/irregular heartbeats	☐	
Dizziness	☐	
Sweating .	☐	
Swelling	☐	
Nausea	☐	
Vomiting	☐	
Stomach pain	☐	
Diarrhea	☐	
Constipation	☐	

(continued on back)

	Yes	
Other change in bowels	☐	
Excessive thirst	☐	
Excessive urination	☐	
Up during night to urinate	☐	
Yeast infections	☐	
Discharge from breasts	☐	
Enlargement of breasts	☐	
Change in libido	☐	
Problems with erections	☐	
Change in ring/shoe/hat size	☐	
New spacing of teeth	☐	
Easy bruising	☐	
Tremors/shaking of hands	☐	
Numbness or tingling	☐	
Feel hot/cold most of time	☐	
Muscle aches	☐	
Joint aches	☐	
Weakness	☐	
Change in moods	☐	
Irritability	☐	
Change in memory	☐	
Problems concentrating	☐	
Change in skin	☐	
Acne	☐	
Change in hair	☐	
Excessive hair growth	☐	
Other	☐	

FOR WOMEN:

At what age did you start having menstrual periods? _____

When was your last menstrual period? _____

Has there been any change in your periods? _____

How many times have you been pregnant? _____