

Date \_\_\_\_\_

## Medical History Questionnaire

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Please circle one: Married Single Divorced Widow

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Children (names, year of birth): \_\_\_\_\_

### Previous Medical History: (Please list age or year if possible)

Childhood illnesses: \_\_\_\_\_

Last tetanus shot: \_\_\_\_\_

Hospitalizations or surgeries: \_\_\_\_\_

Date of last colon cancer screening: \_\_\_\_\_

### Health Habits:

Do you use tobacco? \_\_\_\_\_ How much per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much per week? \_\_\_\_\_

How much caffeine per day? \_\_\_\_\_

### Circle or list any of the following problems you have had:

\*Weight gain/loss (highest adult weight \_\_\_\_\_ lowest \_\_\_\_\_)

\*Fever/chills/night sweats

\*Headaches/head injuries/concussion/other \_\_\_\_\_

\*Eye problems (wear contacts or glasses?)/other \_\_\_\_\_

\*Ear problems/hearing loss/ringing/pain/other \_\_\_\_\_

\*Thyroid problems or x-ray treatment to neck or chest \_\_\_\_\_

\*Breast masses/breast discharge/breast pain

**Date of last mammogram?** \_\_\_\_\_

\*Breathing problems/shortness of breath/asthma/bronchitis/pneumonia/emphysema/other

\*Heart disease/high blood pressure/rheumatic fever/chest pain/palpitations or skipped beats/heart murmur

**Date of last cholesterol check and results?** \_\_\_\_\_

\*Heartburn/swallowing difficulty/ulcers/gallstones/food intolerance/constipation/diarrhea/bloody or black bowel movements/abdominal pain/hernia

\*Kidney or bladder infection/loss of urine control/pain with urination/kidney stones/poor urine stream/ blood in urine

\*Muscle pain/joint pain or swelling/broken bones/dislocations/muscle weakness

\*Seizures/loss of coordination/tremors/speech problems/memory loss/numbness/tingling

\*Skin changes/mole change/skin infections/hair loss/psoriasis

\*Bleeding from any site/clotting problems/bruising easily/transfusions (what year? \_\_\_\_\_)

\*Depression/poor sleeping/appetite problems/panic attacks/suicidal thoughts or attempts

\*Concerns about sexuality or sexual function? \_\_\_\_\_

### **Males:**

Prostate enlargement or infection/discharge from penis/herpes, venereal warts or other sexually spread diseases/sexual problems/lumps in testes/swelling in scrotum/infertility/birth control questions

### **Females:**

Age at first period \_\_\_\_\_ Last normal period \_\_\_\_\_

Periods that are heavy/irregular/short/painful/missing/bleeding between periods  
Herpes/venereal warts/other sexually spread infections/infertility/sexual problems?

Pregnant? Yes No Not sure

Age at first pregnancy \_\_\_\_\_

PAP smears—month and year of last one \_\_\_\_\_ Any abnormal smears? \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Full term births \_\_\_\_\_

Premature \_\_\_\_\_ Miscarriages \_\_\_\_\_

Abortions \_\_\_\_\_ Living children \_\_\_\_\_

Birth control questions? Yes No

**Family Medical History** Family Name: \_\_\_\_\_

Have any family members had any health problems? Please consider any of the following:  
diabetes/heart disease/heart attacks/heart surgery/high blood pressure/stroke/high cholesterol/  
cancer/tuberculosis or other lung disease/ulcers or liver disease/kidney stones/arthritis/severe  
depression or suicide

Current age or age at death	Health problems
Father _____	_____
Mother _____	_____

Did your mother have to take medication to prevent miscarriages? Yes No Not sure

Please list all your brothers, sisters and children, along with any health problems they may have: \_\_\_\_\_

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Any health problems of grandparents, aunts, uncles, and/or cousins? \_\_\_\_\_

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Any other health concerns you would like to discuss? \_\_\_\_\_

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Please keep in mind the time limitations of your appointment. It may be best to schedule additional follow-up appointments in order to adequately address your concerns.

Date \_\_\_\_\_

Signed \_\_\_\_\_