

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: _____

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

Any other health concerns you would like to discuss? _____

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 _____

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