PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Age: _____ DOB: _____ HT: _____ WT: _____ Last Tetanus Shot: _____

ALLERGIES: _____

Current Medications: (if multiple medications, give medical asst. list once you are in the exam room)

_____

Marital Status: (Circle one) Single - Married - Widowed - Divorced

Occupation:_____

How often do you intake alcohol? # of drinks: _____ : (circle one) Daily Weekly Monthly Yearly

Do you smoke? No Yes If yes, how many packs per day? _____ and for how many years? _____ If quit, what year_____

Pharmacy Name: _____ Town: _____ Phone: _____

Please answer Y or N to the following. Do you have or have you ever had…

Cardio-Vascular Disease	No	Yes		Diabetes	No	Yes		Thyroid Disease	No	Yes
High Blood Pressure	No	Yes		Kidney Disease	No	Yes		Skin Disorder	No	Yes
Rheumatic Fever	No	Yes		Kidney Stones	No	Yes		Lymes Disease	No	Yes
Pneumonia	No	Yes		GI Ulcer	No	Yes		Seizures/Fainting	No	Yes
Tuberculosis	No	Yes		Anemia	No	Yes		Head/Spinal Injury	No	Yes
Asthma	No	Yes		Blood Disorder	No	Yes		Colon Polyps	No	Yes
Hepatitis	No	Yes		Psych Disorder	No	Yes		Colon/Rectal Cancer	No	Yes

Please list names and towns of any other Doctors you see

Cancer	No	Yes	If yes, type/location	
Bone/Muscular Disorders	No	Yes	If yes, type	
Sexually Trasmitted Disease	No	Yes	If yes, type	
Eating Disorder	No	Yes	If yes, type	
Substance Abuse	No	Yes	If yes, type	
Other Medical History:				

Primary Care:_____

Cardiologist: _____ Neurologist: _____

Endocrinologist: _____ Urologist: _____

Gastro: _____ ENT: _____

Others: _____

Important Family History – Please write mother/father/sibling/paternal grand(mother or father)/maternal grand(mother/father) next to each that applies.

Anemia _____
Diabetes _____
Thyroid Disease _____
Heart Disease _____
Tuberculosis _____
Cancer _____

High Blood Pressure _____
Kidney Disease _____
Asthma _____
Hepatitis _____
Cancer _____ Please indicate type
Cancer _____