

**Medical History Questionnaire**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

Please list any **ALLERGIES:** \_\_\_\_\_  
 \_\_\_\_\_

Please list any **MEDICINES & DOSAGES** you are currently taking, including aspirin, vitamins, or herbal supplements.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Pharmacy & Location:** \_\_\_\_\_

**Past Medical History** (Please check all that apply)

<input type="checkbox"/> Aids/HIV	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis ABC
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Seizures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Rheumatoid			
<input type="checkbox"/> Osteoarthritis			
<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> Hypertension / High Blood Pressure	

Please list any other condition: \_\_\_\_\_

Please elaborate on any conditions listed: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Surgical History**

Surgery Intervention	Year	Surgeon

**Past Family History** Please apply the following diseases / conditions to each family member as appropriate:

Family Member	Age	Disease	Deceased (Y/N)
Father			
Mother			
Brother			
Sister			
Grandfather – Maternal			
Grandmother – Maternal			
Grandfather – Paternal			
Grandmother – Paternal			

# of Children	Ages
Son(s)	
Daughter(s)	

**Social History**

<u>Tobacco</u>	<u>Alcohol</u>	<u>Illegal Drugs</u>
Yes – No - Former	Yes – No - Former	Yes – No - Former
Amt.:	Amt.:	
Type:		
Yrs Smoked:		
Yr. Quit:	Yr. Quit:	

**Physical Assessment**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Right Handed or Left Handed (please circle)

First Menstrual Period: \_\_\_\_\_ Most Recent Menstrual Period/Menopause: \_\_\_\_\_

**Activities/Exercises/Sports:** \_\_\_\_\_  
 \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

Date: \_\_\_\_\_

Or

**Signature of Person Completing this Form:** \_\_\_\_\_