Medical History Questionnaire

Patient Name: ____________________ Date of Birth: __________

Healthcare Reform Act requires collecting the following information for a comprehensive examination.

Do you currently, or have you ever had any problems in the following areas: (please circle choices)

ALLERGIC to anything? Yes No (circle)

CARDIOVASCULAR

Angina	Arrhythmia	Arteriosclerosis
Cardiovascular Disease	Congestive Heart	Elevated Cholesterol
Hypertension	Stroke	Other Cardiovascular

CONSTITUTIONAL

Appetite (Excess)	Appetite (Loss)	Anemia
Blackouts	Car sickness	Chills
Colds	Coughing	Dizziness
Fainting	Fatigue	Fever
Growth (Excess)	Nausea	Nose bleeds
Sweating	Thirst (Excess)	Vomiting
Weight Gain	Weight Loss	Other

ENDOCRINE

Crohn's Disease	Diabetes Type 1	Diabetes Type 2
Diabetic Suspect	Gout	Hyperglycemia
Pituitary Disorder	Renal Disease	Thyroid Disorder

GASTROINTESTINAL

Acid-Reflux	Cancer: Colon	Cancer: Liver
Cirrhosis	Colitis	Diverticulosis
Dyspepsia	Gastroenteritis	Gastrointestinal Disorder
Hepatitis	Hepatic (Liver) Disease	
Ulcer: Duodenal	Ulcer: Peptic	Ulcer: Stomach

GENITOURINARY

Bladder Infection	Kidney Stones	Menopause
Ovarian Cyst	Ovarian Tumor	Pelvic Inflam. Disease
Prostate Disorder	Prostate Cancer	Uterine Cancer

EARS, NOSE MOUTH THROAT

Chronic Cough	Dry Mouth	Ear Infection
Encephalitis	Gingivitis	Headaches
Headaches (Migraine)		Hearing Loss (Impaired)
Meniere's Syndrome		Sinusitis

HEMATOLOGIC / LYMPHATIC

Anemia	Breast Carcinoma	Hematologic (Blood) Disorder
Hodgkin's Disease	Leukemia	Lymphatic Cancer
Sickle Cell Disease		

IMMUNOLOGIC

Bacterial Infection	Histoplasmosis	Influenza
Lyme disease	Sarcoidosis	Viral Infection

INTEGUMENTARY (Skin)

Acne	Acne Rosacea	Albinism
Atopic Dermatitis	Contact Dermatitis	Dermatitis
Dry Skin	Erythema Multiforme (red skin – rash)	
Hemangioma	Hypertrichosis	Impetigo
Lupus	Photosensitivity	Psoriasis
Pruritus	Raynaud's Disease	Sarcoid Lesion
Scleroderma	Sunburn	Urticaria
Vitiligo	Warts	Xeroderma

MUSCULOSKELETAL (BONES/ JOINTS/ MUSCLES)

Ankylosing Spon.	Arthritis	Arthritis: Rheumatoid
Down's Syndrome	Marfan's	Muscular Dystrophy
Myasthenia Gravis	Osteoporosis	Scoliosis

NEUROLOGICAL

Bell's Palsy	Brain Damage	Brain Tumor
Cerebral Palsy	Dyslexia	Encephalitis
Epilepsy	Headache	Headache (Migraine)
Muscular Dystrophy	Multiple Sclerosis	Myasthenia Gravis
Neuralgia	Parkinson's	Seizure Disorder
Spinal Cord Injury	Vertigo	von Hippel-Lindau Disease

PSYCHIATRIC

Attention Disorder-ADD	Alcoholism	
Alzheimer's Disease	Anorexia	Anxiety Disorder
Autism	Bi-Polar Disorder	Brain Damage (Trauma)
Bulimia	Delusions	Dementia
Depression	Insomnia	Learning Disability
Memory Loss (Short-Term)		Mentally Challenged

RESPIRATORY

Asthma	Bronchitis	Cancer: Lung
COPD	Cystic Fibrosis	Emphysema
Lung Disease	Lung Cancer	Pneumonia
Pleurisy	Sarcoidosis	Tuberculosis

If you have a health condition not listed, please explain:

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Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Alcohol use? ❑ None ❑ Social use only ❑ 1 or 2 drinks a day ❑ Above average use ❑ Alcohol dependence

Narcotic use? ❑ None ❑ Recreational use ❑ Chemical dependence

Tobacco use? ❑ Never Smoked ❑ Former smoker, When did you stop smoking? ______________________

❑ Current every day smoker ❑ Current some days smoker ❑ Smokeless User

Sexually Transmitted Disease? ❑ None ❑ Yes ❑ HIV Positive

Blood Transfusion Disease? ❑ None ❑ Yes ❑ HIV Positive

Birth Order? ❑ First ❑ Second ❑ Third ❑ Fourth ❑ Fifth ❑ > Fifth ❑ Only child ❑ Identical twin ❑ Fraternal twin

Females: Pregnant? ❑ Yes ❑ No If yes, which trimester? ❑ First ❑ Second ❑ Third

Breast Feeding? ❑ Yes ❑ No