Jefferson®

Medical History Questionnaire

MRN #_____

Patient Name *(Please Print)*:_____ Date of Birth:_____

Provider you are seeing today: _____ Today's Date:_____

Please state your problem in your own words as to why you are here today:

_____

Did a physician request that you see one of our providers today? ☐Yes ☐No If yes, name of physician:_____

☐Acute Myocardial Infarction (Heart Attack)
☐Anemia (Low Blood Count)
☐Arthritis
☐Asthma
☐Autoimmune Disorder (Lupus/Scleroderma/RA)
☐Blood Transfusion Complications
☐Cancer - list type(s):

_____

_____

☐Chest Pain (Angina)
☐Chronic Liver Disease
☐COPD (Chronic Obstructive Pulmonary Disease)
☐Diabetes Mellitus
☐Emotional Disturbance
☐Gastric/duodenal Ulcer
☐Heart Disease
☐Heartburn
☐Hepatic (Liver) Disorder
☐Hepatitis
☐HIV Infection
☐Hypercholesterolemia
☐Hypertension
☐Irritable Bowel Syndrome
☐Kidney Disease
☐Lower Back Pain
☐Mitral Valve Disorder
☐Murmurs
☐Obesity
☐Obstructive Sleep Apnea
☐Osteoporosis
☐Peripheral Vascular Disease (Poor Circulation)
☐Pneumonia
☐Pulmonary Disease (Lung Disease)
☐Recent Methicillin-resistant Staph aureus (MRSA)
☐Rheumatic Fever
☐Seizure Disorder
☐Sinusitis
☐Stroke Syndrome
☐Thromboembolic Disease (Blood Clot Disorder)
☐Thrombophlebitis
☐Thyroid Disorder
☐Transient Ischemic Attack (Mini Stroke)
☐Tuberculosis
☐Other (specify):

_____

_____

_____

Surgery: ☐No Surgical History

Surgery	Date	Surgery	Date

Family History *(check all that apply)*: ☐No Family Medical History

	Family Member*		Family Member*
☐Anemia (Low Blood Count)		☐Hypercholesterolemia	
☐Cancer - list type(s):		☐Hypertension	
		☐Osteoporosis	
		☐Pulmonary Disease	
☐COPD		☐Renal Disease	
☐Diabetes Mellitus		☐Stroke Syndrome	
☐Emphysema		☐Thromboembolic Disease	
☐Heart Disease		☐Unattainable-Patient Adopted	
☐Hepatic (Liver) Disorder		☐Other:	
Family Health Status of Father - Deceased	Age:	Cause	
Family Health Status of Mother - Deceased	Age:	Cause	

Medical History Questionnaire *(PAGE 2 of 2)* MRN #_____

Patient Name:_____ Date of Birth:_____

Social History:

Marital Status: ☐Married ☐Single ☐Widowed ☐Separated ☐Divorced ☐Life Partner

(check all that apply)

☐Alcohol Use: Weekly:_____

☐Drug Use (Recreational): Explain:_____

☐Use Intravenous Drugs: Explain:_____

☐Previous History of Smoking: Date Quit:_____ Packs Per Day_____ Years of Smoking:_____

Attempts to Quit:_____ Methods Used to Quit:_____

☐No History of Smoking ☐Wishing to Stop Smoking

☐Smoking/Nicotine Substances: ☐Cigarettes Packs/times Per Day:____ Years_____

☐Cigars ☐Chewing ☐Tobacco ☐Pipe

☐Current Diet: Explain:_____

☐Occupation: List All:_____

☐Travel: If recently out of the country, where?_____

Do you have an advanced directive? ☐Yes ☐No

Allergies: ☐No Known Allergies

Allergy	Reaction	Allergy	Reaction

Medications (Include vitamins, herbal supplements and over the counter medications): ☐No Current Medications

Medications	Dosage	Frequency	Reason for Taking

Have you participated in any clinical trials or used experimental drugs? ☐Yes ☐No Explain:_____

Are you pregnant? ☐Yes ☐No Last Menstrual Period Date:_____

Is there anything else about your medical history that we should know?

Patient Signature:_____ Date:_____ Time:_____

I certify that I have reviewed the above information with the patient.

Physician Signature:_____ Date:_____ Time:_____