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:

Headache, Nausea and Lack of Sleep

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: ***Hironmay Basu*** Date:02/13/2022 Time: 12:08 pm PST

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

Physician Signature:_____ Date:_____ Time:_____