



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: _____

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Acute Myocardial Infarction
(Heart Attack) | <input type="checkbox"/> Chronic Liver Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anemia (Low Blood Count) | <input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease) | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Mitral Valve Disorder | <input type="checkbox"/> Stroke Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Murmurs | <input type="checkbox"/> Thromboembolic Disease (Blood Clot Disorder) |
| <input type="checkbox"/> Autoimmune Disorder (Lupus/Scleroderma/RA) | <input type="checkbox"/> Gastric/duodenal Ulcer | <input type="checkbox"/> Obesity | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Blood Transfusion Complications | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer - list type(s): | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Transient Ischemic Attack (Mini Stroke) |
| | <input type="checkbox"/> Hepatic (Liver) Disorder | <input type="checkbox"/> Peripheral Vascular Disease (Poor Circulation) | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other (specify): _____ |
| | <input type="checkbox"/> HIV Infection | <input type="checkbox"/> Pulmonary Disease | |
| | | (Lung Disease) | |
| <input type="checkbox"/> Chest Pain (Angina) | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Recent Methicillin-resistant Staph aureus (MRSA) | |
| | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatic Fever | |
| | <input type="checkbox"/> Irritable Bowel Syndrome | | |

Surgery: No Surgical History

Surgery	Date	Surgery	Date

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

	Family Member*		Family Member*
<input type="checkbox"/> Anemia (Low Blood Count)		<input type="checkbox"/> Hypercholesterolemia	
<input type="checkbox"/> Cancer - list type(s):		<input type="checkbox"/> Hypertension	
		<input type="checkbox"/> Osteoporosis	
		<input type="checkbox"/> Pulmonary Disease	
<input type="checkbox"/> COPD		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> Stroke Syndrome	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Thromboembolic Disease	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Unattainable-Patient Adopted	
<input type="checkbox"/> Hepatic (Liver) Disorder		<input type="checkbox"/> Other: _____	

Family Health Status of Father - Deceased Age: Cause

Family Health Status of Mother - Deceased Age: Cause

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: _____