MEDICAL HISTORY QUESTIONNAIRE

NAME _____ AGE _____ BIRTHDATE _____ DATE TODAY _____

PAST HISTORY CHECK ANY OF THE FOLLOWING YOU HAVE HAD. IF IN DOUBT, PUT A QUESTION MARK.

- ☐ MUMPS
- ☐ MEASLES
- ☐ GERMAN MEASLES
- ☐ CHICKEN POX
- ☐ WHOOPING COUGH
- ☐ POLIO
- ☐ TYPHOID
- ☐ RHEUMATIC FEVER
- ☐ HEART TROUBLE
- ☐ HEART MURMUR
- ☐ HIGH BLOOD PRESSURE
- ☐ GOUT
- ☐ ARTHRITIS
- ☐ PNEUMONIA
- ☐ TB
- ☐ ASTHMA
- ☐ HAY FEVER
- ☐ ECZEMA
- ☐ ALLERGY OR UNDESIRABLE REACTION TO ANY MEDICINES OR INJECTIONS
- ☐ OTHER ALLERGIES
- ☐ KIDNEY STONES
- ☐ KIDNEY INFECTION
- ☐ BLADDER INFECTION
- ☐ LIVER DISEASE
- ☐ HEPATITIS
- ☐ GALLBLADDER DISEASE
- ☐ JAUNDICE (YELLOW EYES OR SKIN)
- ☐ STOMACH ULCER
- ☐ DUODENAL ULCER
- ☐ EPILEPSY (FITS, BLACKOUTS)
- ☐ GLAUCOMA
- ☐ DIABETES
- ☐ THYROID TROUBLE
- ☐ ANEMIA
- ☐ ABNORMAL BLEEDING TENDENCY
- ☐ PHLEBITIS (CLOTS IN VEINS)
- ☐ FATIGUE

YEAR	FRACTURES OR SERIOUS INJURIES

YEAR	OTHER UNUSUAL OR SERIOUS ILLNESS

YEAR	OPERATIONS

YEAR	OTHER HOSPITALIZATIONS

FAMILY HISTORY — NAME	ILLNESSES	AGE, IF LIVING	AGE, IF DECEASED	CAUSE OF DEATH, IF DECEASED
FATHER				
MOTHER				
BROTHERS AND SISTERS				
HUSBAND OR WIFE				
CHILDREN				

CIRCLE IF ANYONE IN YOUR FAMILY HAS HAD THE FOLLOWING: RHEUMATIC FEVER, EPILEPSY, TB, DIABETES, CANCER, GLAUCOMA, GOUT, HIGH BLOOD PRESSURE, PEPTIC ULCER, ASTHMA, ALLERGIES. ☐ NONE OF THESE.

HABITS INDICATE YOUR USUAL AMOUNT OF:

COFFEE _____ DECAF COFFEE: _____ ALCOHOL _____

TEA _____ COLA _____ SLEEP _____

SMOKING _____ MILK _____ EXERCISE _____

DO YOU FOLLOW A SPECIAL DIET OR OBSERVE DIETARY RESTRICTIONS? _____ IF YES, DESCRIBE: _____

HOW OFTEN DO YOU WEAR AUTO SEAT BELTS? _____

PRESENT OCCUPATION _____

PRIOR OCCUPATIONS _____

LIST ALL VITAMINS, LAXATIVES AND MEDICINES YOU USE, AND AMOUNTS USED _____