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MEDICAL HISTORY QUESTIONNAIRE

DATE______________________

NAME____AGE____ HOME PHONE__________________
(FIRST) (MIDDLE) (LAST) BUS PHONE__________________

ADDRESS____
(STREET) (CITY) (STATE) (ZIP)

DATE OF BIRTH___/___/___ RELIGION______________________
OCCUPATION______________________________ EMPLOYER________________________________
SOCIAL SECURITY NUMBER________________________MARRIED___#YEARS/___DIVOR.___WIDOWED/___SINGLE
HUSBAND'S NAME____SOCIAL SECURITY #__________________
(FIRST) (MIDDLE) (LAST)

HUSBAND'S EMPLOYER______________________________ BUS PHONE__________________
NAME OF RELATIVE OR FRIEND (AT ANOTHER ADDRESS)________________________PHONE#__________________
REFERRED BY______________________ FAMILY PHYSICIAN____________________ PHONE #__________________

MEDICAL INSURANCE______________________________ID# OR POLICY#__________________________

1. Present complaints____
____

2. Kind & Date of all surgical operations:
(a)
(b)
(c)

3. Name & date of serious medical illness/hospitalizations:
(a)
(b)
(c)

4. Medications you are presently taking:
(a)
(b)
(c)

5. List all drugs allergies:
(a)
(b)
(c)

6. Dates of last 2 menstrual periods:
(a)
(b)

7. What type of birth control are you presently using:
(if any)

8. Pregnancy:
(a) number of pregnancies________
(b) number of living children_______
(c) miscarriages________________
(d) abortions__________________

9. Has anyone in you immediate family (father, mother, grandparents, brothers, sisters, or children) ever had:

______cancer
______diabetes
______heart trouble
______high blood pressure
______genetic disorders
______seizures
______stroke
______other

10. Date of last cancer (pap) smear______________

11. Check any of the following that you have ever had:

____frequent headaches
____dizzy spells
____asthma
____rheumatic fever
____vomiting of blood
____recurrent diarrhea
____presently smoking
____bloody urine
____burning with urination
____thyroid problems
____hepatitis (liver disease)
____emotional problems
____drugs (LSD, heroin, etc)

____trouble with eyes or vision
____shortness of breath
____heart murmur
____emphysema
____blood in stool
____persistent nausea/vomiting
____aching or painful joints
____inability to control urine
____urinary frequency
____high blood pressure
____jaundice
____sexual difficulties
____cough up blood

____convulsions or paralysis
____recurrent chest pain
____easy bruising or bleeding
____blood clot in vein (thrombophlebitis)
____persistent or severe abdominal pain
____drinking problems
____hernia
____recurrent bladder infections
____diabetes
____blood transfusion
____recent weight change (involuntarily)
____venereal disease
____desired psychiatric help

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