

MEDICAL HISTORY QUESTIONNAIRE

DATE OF 1ST VISIT: _____

NAME _____

AGE _____ SEX _____ RACE _____

ADDRESS _____

BIRTHDATE _____

CITY _____ STATE _____ ZIP CODE: _____

PHONE: HOME _____ WORK _____

PERSONAL PHYSICIAN _____

REFERRED BY _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

PHONE _____ FAX: _____

FAMILY HISTORY (check if present now or ever in the past)

BROTHERS, SISTERS, PARENTS, GRANDPARENTS, AUNTS, UNCLAS AND CHILDREN

- OBESITY HEART DISEASE DRUG ABUSE
 DIABETES STROKE DEPRESSION
 HIGH BLOOD PRESSURE ARTHRITIS PANIC ATTACKS
 CANCER ALCOHOLISM EMOTIONAL ILLNESS

SPOUSE (check if present now or even in the past)

- HEALTH PROBLEMS (LIST) _____
 SUBSTANCE ABUSE: ALCOHOL DRUGS
 DEPRESSION
 MARITAL DISCORD
 OBESITY

PATIENT PROFILE

- MARRIED SINGLE WIDOWED DIVORCED
CHILDREN # _____ AGES _____
OCCUPATION _____ SPOUSE OCCUPATION _____
EXERCISE: TYPE _____ FREQUENCY _____
SMOKING: PACKS/DAY _____ X _____ # YEARS
ALCOHOL: TYPE _____ QUANTITY _____ DAYS/WEEK
COFFEE: CUPS/DAY: # DECAF _____ # REG. _____ # SODAS w/CAFFEINE/DAY _____

- OTHER WORK DISABILITY: DATE _____
NATURE OF INJURY _____
L&I CASE # _____
TREATING MD _____
ADDRESS _____
PHONE _____

PAST MEDICAL HISTORY

SURGERY: TYPE _____ DATE _____

MEDICAL HOSPITALIZATIONS:

DIAGNOSIS _____ DATE _____

SPECIAL DIAGNOSTIC STUDIES (LIST, e.g. CT, MR, ARTERIOGRAMS) _____

IMMUNIZATIONS (DATE):

TETANUS _____ (DATE): POLIO _____ (DATE) DIPHTHERIA _____ (DATE): OTHER _____ (DATE):

CHILDHOOD ILLNESS: RHEUMATIC FEVER MEASLES MUMPS CHICKEN POX OTHER _____

ANY HISTORY OF THE FOLLOWING CONDITIONS:

- HIGH BLOOD PRESSURE _____
 DIABETES _____
 ANGINA, HEART ATTACK _____
OR OTHER HEART DISEASE _____
 STROKE _____
 GOUT _____
 ARTHRITIS _____
 PHLEBITIS _____
 GALLBLADDER /LIVER DISEASE _____
 THYROID _____
 DAYTIME DROWSINESS _____
 KIDNEY DISEASE _____
 ULCER DISEASE, HIATAL HERNIA _____
 BOWEL DISEASE _____
 ASTHMA/LUNG DISEASE _____
 PSYCHIATRIC ILLNESS _____
 ALCOHOLISM _____
 DEPRESSION _____

ALLERGIES

DRUGS, FOODS _____

CURRENT MEDICATIONS:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG AND YOUR DOSEAGE

FREQUENCY (X/DAY)

(OVER PLEASE)

EFM Location

REVIEW OF SYMPTOMS (CHECK BOX IF PRESENT NOW)

SKIN

- NAIL CHANGES
- ITCHING
- BRUISING
- LESIONS

EYES

- CHANGE IN VISION
- PAIN
- IRRITATION
- LAST EYE EXAM (DATE) _____
DR: _____

EARS, NOSE, THROAT

- PAIN
- DISCHARGE
- RINGING SOUND
- HEARING LOSS
- NOSE BLEEDS
- FACE PAIN
- SORE THROAT
- DENTAL/GUM DISEASE
- SWELLING IN NECK

RESPIRATORY

- WHEEZING
- COUGH
- SPUTUM PRODUCTION/WITH BLOOD
- SHORTNESS OF BREATH
WITH EXERCISE
AT NIGHT

CARDIOVASCULAR

- CHEST PAIN/ANGINA
- PALPITATIONS
- CRAMPS IN LEGS WHEN WALKING
- LEG/ANKLE SWELLING
- BLOOD CLOTS/ PHLEBITIS

GASTROINTESTINAL

- INDIGESTION/HEARTBURN
- NAUSEA/VOMITING WITH BLOOD
- CONSTIPATION
- DIARRHEA
- BLOODY OR BLACK STOOLS
- ABDOMINAL PAIN
- LOSS OF APPETITE
- DIFFICULTY SWALLOWING
- ANAL DISCOMFORT
- FATTY FOOD INTOLERANCE
- HEMORRHOIDS

NEUROLOGIC

- DIZZINESS
- FAINTING
- SEIZURES
- HEADACHES
- TREMOR
- NUMBNESS/TINGLING
- WEAKNESS
- SLURRED SPEECH

PSYCHOLOGICAL

- DEPRESSION/BLUE MOODS
- PANIC ATTACKS
- HYPERVENTILATION
- ANXIETY
- SLEEP DISTURBANCES
- HISTORY OF PHYSICAL OR SEXUAL ABUSE

SUBSTANCE ABUSE (current or past)

- ALCOHOL
- PRESCRIPTION DRUGS
- OTHER _____

JOINTS/MUSCLES

- PAIN
- SWELLING
- STIFFNESS
- REDNESS
- BACK PAIN

ENDOCRINE/OBESITY

- DAYTIME DROWSINESS
- LOUD SNORING/CHOKING WHEN ASLEEP
- SLEEP STUDY
- HEAT/COLD INTOLERANCE
- HYPOGLYCEMIA
- EXCESSIVE HAIR GROWTH/LOSS
- INCREASED THIRST/URINATION
- WEIGHT LOSS (#LBS) _____

GENITO-URINARY

- PAIN ON URINATION
- FREQUENCY DAY/NIGHT
- URGENCY
- BLOOD IN URINE
- HESITANCY
- IMPOTENCE
- LESIONS
- DISCHARGE
- FREQUENT INFECTIONS

BREAST

- DISCHARGE FROM NIPPLE
- PAIN
- LUMP
- INSTRUCTED SELF EXAM (DATE) _____
- LAST BREAST X-RAY (MAMMOGRAM) _____

REPRODUCTIVE

- LAST PAP SMEAR (DATE) _____ NL ABNL
- TYPE OF BIRTH CONTROL _____
- AGE OF FIRST MENSES _____ LENGTH OF CYCLE _____ DAYS
- DURATION OF MENSTRUAL FLOW _____ DAYS
- LT MED HEAVY PAINFUL MENSES
- NUMBER OF PREGNANCIES _____ LIVE BIRTHS _____
- DISCHARGE/FOUL ODOR/ITCH
- PAIN WITH INTERCOURSE
- VAGINAL DRYNESS

PRE-MENSTRUAL SYMPTOMS

- STRONG FOOD CRAVINGS (list) _____
- FOOD BINGES
- MOOD CHANGE
- SWELLING
- PURGING (VOMITING, LAXATIVE OR DIURETIC USE
FOR WEIGHT LOSS)