Medical History Questionnaire
Established Patient

Name:_____ Date:_____ D.O.B.:_____

Health Maintenance Review:

Last eye exam:_____
Last cholesterol result:_____
Last Proctoscopy:_____
Last rectal exam:_____
Women:
Last Mammogram:_____
Last pelvic/Pap:_____
Any abnormal pap tests?_____

Immunizations:

Last Tetanus:_____
Last Flu Vaccine:_____
Have you had the Pneumonia Vaccine?_____
TB skin test:_____
Have you had Chickenpox?_____

Personal Health Review:

General:

How do you judge your overall health?_____
Do you often worry about your health?_____

Weight loss more than 10 pounds this year?	No___	Yes___
Fever or chills?	No___	Yes___
Night sweats?	No___	Yes___
Dental/gum problems?	No___	Yes___

Skin:

Rashes or itching?	No___	Yes___

Comments/other_____

Ears:

Hearing problems?	No___	Yes___

Comments/other_____

Eyes:

Changes in vision?	No___	Yes___
Contact lenses?	No___	Yes___

Comments/other_____

Nasal Problems:

Chronic nose problems?	No___	Yes___
Hay fever?	No___	Yes___

Comments/other_____

Throat and Neck:

Hoarseness?	No___	Yes___
Lumps or Swelling?	No___	Yes___

Comments/other_____

Lungs:

Cough?	No___	Yes___
Wheezing?	No___	Yes___
Shortness of breath	No___	Yes___
History of Tuberculosis?	No___	Yes___

Comments/other_____

Heart:

Chest pain or tightness?	No___	Yes___
Skipped heart beats?	No___	Yes___
Heart Murmur?	No___	Yes___
High Blood Pressure?	No___	Yes___
Trouble breathing/night?	No___	Yes___
Leg swelling?	No___	Yes___
History of Blood Clots?	No___	Yes___
History/Rheumatic Fever?	No___	Yes___

Comments/other_____

Stomach and Intestines:

Nausea, vomiting?	No___	Yes___
Heartburn, indigestion?	No___	Yes___
Abdominal pain?	No___	Yes___
Constipation?	No___	Yes___
Diarrhea?	No___	Yes___
Bloody or black stool?	No___	Yes___
History of Irritable Bowel?	No___	Yes___
History of Liver Disease?	No___	Yes___

Comments/other_____

Urinary Tract:

Excessive urination or urgency?	No___	Yes___
Nighttime urination?	No___	Yes___
Painful urination?	No___	Yes___
Weak stream/Dribbling?	No___	Yes___
Blood in urine?	No___	Yes___
Urine leakage?	No___	Yes___
Sexual concerns?	No___	Yes___
History/prostate problems?	No___	Yes___

Comments/other_____

Reproductive (women only):
Date of last menstrual period_____
Are periods regular? No___ Yes___
Age of onset of Menopause_____
Number of pregnancies_____
Number of children_____
Number of miscarriage(s) or abortion(s)
History of Breast Disease? No___ Yes___
If applicable, method of birth control_____
Comments/other_____

Muscle and Bone:
Painful or swollen joints? No___ Yes___
Back pain? No___ Yes___
History of Osteoporosis? No___ Yes___
History of Gout? No___ Yes___
Comments/other_____

Nervous System:
Headache? No___ Yes___
Dizziness? No___ Yes___
Fatigue? No___ Yes___
Depression? No___ Yes___
Anxious feelings? No___ Yes___
Comments/other:_____

Blood and Metabolism:
Unusual hair growth? No___ Yes___
Heat or Cold Intolerance? No___ Yes___
Bleeding Problems? No___ Yes___
History/Thyroid disease? No___ Yes___
History of Anemia? No___ Yes___
Comments/other_____

Thank you for taking the time to complete this form.