Medical History Questionnaire
Established Patient

Name: _____ Date: _____ DOB: _____

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 the chicken pox? _____

Personal Health Review:

General:

How do you judge your overall health? _____
Do you often worry about your health? _____
Weight loss of 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:

Change 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 heartbeats? 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.