Medical History Questionnaire
New Patient

Name: _____ Date: _____ DOB: _____

How would you like to be addressed? _____

What concerns would you like to discuss with the doctor? _____
_____
_____
_____
_____

Medical History:
Please list active medical problems (e.g. diabetes, high blood pressure) and problems requiring diagnostic evaluation and tests in the past.

Please list dates of previous hospitalizations and surgeries, starting with the most recent first.

Medications:
Do you have allergies to medications or other substances? No ____ Yes ____

If yes, please state substance and reaction. _____

Please list all current medications:

Medication	Dose (mg)	How often?	Since when?

Please list any over the counter medications you take (including vitamins, laxatives, antacids)

_____

_____

_____

Social History and Health Risks:

Marital Status: _____
Number of children: _____

Occupation: _____
Do you smoke? Yes ___ No ___ Quit ___
If yes, packs per day? _____

Do you drink alcohol? Yes ___ No ___
Number of drinks per week?
0-5 ___ 5-10 ___ 10-15 ___ >15 ___

Do you exercise? If yes, type and frequency:

_____

Are you exposed to sexual disease risks?
No ___ Yes ___
Casual Sex? No ___ Yes ___
Homosexual Partners? No ___ Yes ___

Do you have a living will? _____

Family History:

Please check if your parent, brother, sister or child has had any of the following (indicate which family member)
Heart Disease: _____
Diabetes: _____
High Blood Pressure: _____
Colon Cancer/Polyps: _____
Breast Cancer: _____
Other Cancer: _____
Glaucoma: _____
Kidney or Liver Disease: _____
Other: _____

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.