



PATIENT MEDICAL QUESTIONNAIRE

Name _____ Date _____ Patient # _____

Age _____ Birthdate _____ Occupation _____

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Main Complaints

For How Long

- a) _____
- b) _____
- c) _____
- d) _____

Surgery or Hospitalization

Kind of Operation or Illness

When

- a) _____
- b) _____
- c) _____
- d) _____

Past Illnesses Circle any illnesses you have had and write date when

When

When

When

- | | | |
|-----------------------|---------------------------|--------------------|
| Scarlet fever _____ | Unconsciousness _____ | Tuberculosis _____ |
| Pneumonia _____ | High blood pressure _____ | Diabetes _____ |
| Heart attach _____ | Allergy _____ | Chicken Pox _____ |
| Rheumatic fever _____ | Kidney disease _____ | Cancer _____ |
| Liver disease _____ | Anemia _____ | Asthma _____ |

Family History

Age

If living - list any diseases

Age

If deceased list cause

- | | | | |
|-------------------------|-------|-------|-------|
| Father _____ | _____ | _____ | _____ |
| Mother _____ | _____ | _____ | _____ |
| Brother [B] [] _____ | _____ | _____ | _____ |
| or Sister [S] [] _____ | _____ | _____ | _____ |
| [] _____ | _____ | _____ | _____ |
| [] _____ | _____ | _____ | _____ |
| [] _____ | _____ | _____ | _____ |
| Son [S] or [] _____ | _____ | _____ | _____ |
| Daughter [D] [] _____ | _____ | _____ | _____ |

Have any of your blood relatives had the following diseases? (grandparents, blood-related aunts and uncles) Circle if Yes

- | | | | | |
|---------------|--------------|-----------------|----------------------|---------------------|
| Heart disease | Stroke | Kidney disease | Psychiatric disorder | High blood pressure |
| Cancer | Emphysema | Thyroid disease | Congenital disease | Alzheimer's |
| Diabetes | Osteoporosis | Allergy | Tuberculosis | |

Social History

- Tobacco: Yes ___ No ___ How much per day? _____
- Alcohol: Yes ___ No ___ How much per day / week / month / year? _____
- Routinely exercises: Yes ___ No ___ How often? _____
- Number of servings of fruits and vegetables per day? _____
- Caffeine consumption: Yes ___ No ___ Sexually active? Yes ___ No ___ Contraceptive method: _____
- Do you always wear your seat belt? Yes ___ No ___ Do you wear a helmet? Yes ___ No ___

Medicines you are taking or have taken recently:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

Allergy to medicine:

No ___ Yes (list) _____

Systems Review Circle if Yes

Metabolic System

Weight change _____
Warmer / Colder than others _____
Increased sweating _____
Goiter _____
Increased thirst _____
Increased urination _____
Skin, hair, nail changes _____

Head, Eyes, Ears, Nose, Throat

Headache _____
Hearing problem _____
Eye problem _____
Ear pain _____
Dizziness _____
Nasal drainage _____
Sore mouth / throat _____

Cardiovascular

Chest pain _____
Fast / irregular heartbeat _____
Ankle swelling _____
High blood pressure _____
Calf pain with walking _____

Respiratory

Short of breath _____
Wheezing _____
Raise phlegm _____
Cough up blood _____

Urinary

Blood in urine _____
Urinary frequency _____
Pain / burning with urination _____
Empty bladder at night _____
Bladder leakage _____

Female Patients -

Spot or menstruate: ____ Yes ____ No
Every _____ days, for _____ days each period
Age of onset _____ Menopause _____
Last period _____ Last PAP smear _____
Breast changes _____
Calcium intake _____
Do you do self breast exam? ____ Yes ____ No
Number of pregnancies? _____

Male Patients -

Impotence _____
Changes in urinary stream _____
Testicular exam? _____ Scrotal lumps _____

REMARKS: _____

Gastro-Intestinal

Heartburn _____
Nausea / vomiting _____
Trouble swallowing _____
Abdominal pain _____
Blood in stools _____
Jaundice _____
Change in bowel habit _____
Constipation _____
Diarrhea _____
Belching / gas _____
Hemorrhoids _____

Musculoskeletal / Neuro / Psychiatric

Back pain _____
Joint pain _____
Stiff neck _____
Muscle weakness / paralysis _____
Tremor / shakes _____
Numbness / tingling _____
Convulsions _____
Fainting _____
Depression / anxiety _____
Stress _____
Sleep poorly _____

Blood / Lymphatic / Constitutional

Bleeding / Bruising _____
Anemia _____
Enlarged glands _____
Fever _____

Allergic / Immunologic

Hayfever _____
Asthma _____
Rashes / hives _____
Allergies _____

Vaccines:

Tetanus No ____ Yes (when) _____
Pneumonia No ____ Yes (when) _____
Hepatitis B No ____ Yes (when) _____
Flu No ____ Yes (when) _____
MMR No ____ Yes (when) _____

Please list other people in your household:

