MEDICAL HISTORY QUESTIONAIRE

Please check all of the following that you had or have at the present time:

Medical:

Hypertension(high blood pressure): Y[ ] N[ ] High cholesterol/ triglycerides: Y[ ] N[ ]

Heart disease: heart attack [ ] when?_____ Bypass surgery [ ] when?_____ stents[ ]when?_____

Stress test: Y[ ] N[ ] when?_____ atrial fibrillation[ ] heart murmur[ ] heart valve disease[ ]

Lung disease: asthma[ ] COPD[ ] Sleep apnea[ ] on CPAP? Y[ ]N[ ] other_____

Gastrointestinal disease: heartburn/reflux[ ] ulcers[ ] colon polyps[ ] liver disease[ ] irritable bowel[ ]

Hemorrhoids [ ] Other _____ when diagnosed?_____

Kidney disease: kidney stones[ ]when?_____ kidney failure(high creatinine): Y[ ] N[ ] other_____

Men: prostate disease[ ] impotence[ ] **Women**: irregular periods: Y[ ] N[ ] infertility: Y[ ] N[ ] menopause: Y[ ] N[ ] year____

Musculoskeletal: osteoporosis/osteopenia [ ] fractures [ ] what?_____ when?_____ DEXA scan [ ] when?_____

Arthritis [ ] gout [ ] other [ ]_____

Neurologic: seizures [ ] neuropathy[ ] stroke [ ]when?_____ other_____

Psychiatric: depression[ ] anxiety[ ] insomnia[ ] schizophrenia[ ]hospitalization_____

Hematologic/Cancer: [ ] Type:_____ when?_____ anemia[ ] other_____

Allergic/Immunologic/Infectious disease: seasonal allergies[ ] HIV[ ] TB[ ] other _____

Endocrine: Diabetes: Type1 [ ] Type2 [ ] when diagnosed?_____ last eye exam?_____ retinopathy? Y[ ] N[ ]

Thyroid: goiter[ ] hypothyroid[ ] hyperthyroid[ ] nodules[ ]

Parathyroid[ ] Pituitary[ ] Polycystic ovaries(PCOS)[ ] other _____

Other Disorders: _____

Surgical:	**year**		**year**		**year**
Appendectomy[ ]	_____	Hysterectomy: total[ ] partial[ ]	_____	hip: R[ ] L[ ]	_____
Gall bladder[ ]	_____	Tubal ligation[ ]		knee: R[ ] L[ ]	_____
Tonsils[ ]	_____	Breast biopsy[ ]	_____	back/spine [ ]	_____
Hernia: inguinal[ ]	_____	Prostate[ ]	_____		

Cancer surgery _____ Type?_____ Other surgery _____ Type?_____

Review of Systems:

General: usual weight_____ Recent weight change Y[ ] N[ ]:loss/gain ____lbs. over how long?_____

Fevers[ ] nightsweats [ ] insomnia[ ] drug addiction [ ]

Eyes: Last eye exam_____ cataracts Y[ ] N[ ] glaucoma Y[ ] N[ ] other_____

Ears, Nose, Throat: hoarseness [ ] last dental exam_____ other _____

Heart: Chest pain[ ] leg swelling[ ] heartbeats: Irregular[ ] or fast[ ] pain in calves[ ]

Lung: wheezing[ ] shortness of breath[ ] cough[ ]

GI: heartburn[ ] constipation[ ] diarrhea[ ] nausea[ ] vomiting[ ] bleeding[ ]

Urinary: frequent urination[ ] painful urination[ ] slow urination[ ] blood in urine[ ]

Sexual: poor libido[ ] poor erections[ ] irregular periods[ ]

Musculskeletal: Joint pain[ ] back pain[ ] stiffness[ ] muscle weakness[ ] muscle cramps[ ]

Neurologic: headache[ ] numbness[ ] tremor[ ]

Endocrine: Excessive: Hunger[ ] thirst[ ] sweating[ ] urination[ ] intolerance to: heat[ ] cold[ ] hot flashes[ ]

breast discharge[ ] excess hair growth[ ] /loss[ ] decreased energy/tired[ ] difficulty swallowing[ ]

Current Medications:

Allergies to Medications: None[ ] penicillin/ sulfa/ codeine/ contrast/ latex/ aspirin other_____

Habits: smoker: Y[ ] N[ ] how much?_____ how long?_____ when quit?_____

alcohol: Y[ ] N[ ] how much?_____

exercise: Y[ ] N[ ] what type? Walking[ ] jogging[ ] biking[ ] gymnasium[ ] aerobics[ ] _____How often?___

Family History: **Diseases**

Mother: _____ alive[ ] deceased[ ] age____

Father: _____ alive[ ] deceased[ ] age____

Brothers: How many? ____ Sisters: How many?_____ Children: How many? _____

Signed_____ Date_____