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Patient Medical History Questionnaire

Name: ____________________________ **Date:** ______________________

Date of Birth: ____________________

Check "YES" for anything that has been diagnosed, treated, or is a recurring problem:	YES	NO	Date of Onset	✓ if Cont.
Allergic Reaction to Medicines or Injections				
If Yes, Specify Med & Describe Reaction: ____________________ ____________________				
1. EARS, NOSE and THROAT				
Hearing Problems				
Poor Balance or Dizziness or Vertigo				
Frequent Cough/Coughing up Phlegm or Blood				
Persistent Hoarseness or Difficulty Swallowing				
Perennial Allergic Rhinitis (Year Long Symptoms)				
Non-Allergic Rhinitis				
Seasonal Allergic Rhinitis (Spring & Fall Symptoms)				
Other Ears, Nose, and/or Throat Conditions:				
2. OPHTHALMIC				
Corrected Vision (eye glasses or contact lenses)				
Glaucoma				
Cataracts (including surgery)				
Other Eye Conditions				

Check “YES” for anything that has been diagnosed, treated, or is a recurring problem:	YES	NO	Date of Onset	✓ if Cont.
3. RESPIRATORY				
Asthma				
Nocturnal (Night Time) Asthma				
Exercise Induced Asthma				
Emphysema/COPD/Chronic Bronchitis				
Acute Bronchitis/Pneumonia				
Collapsed Lung				
Shortness of Breath				
A Positive TB Test				
Previous Chest X-Ray: _________ Date: ___________________				
Other Respiratory Conditions				
4. CARDIOVASCULAR				
Heart Murmur/Heart Valve Defects				
Angina/Chest Pain				
Heart Attack				
High Blood Pressure				
Stroke				
Palpitations or Irregular Heartbeat				
Rheumatic Fever				
Edema (Swollen Feet/Legs)				
Elevated Cholesterol				
Other Cardiovascular Conditions				

Check “YES” for anything that has been diagnosed, treated, or is a recurring problem:	YES	NO	Date of Onset	✓ if Cont.
5. GASTROINTESTINAL				
Stomach Ulcer				
Gallstones or Gallbladder Problems				
Heartburn				
Recurrent Diarrhea or Constipation				
Spastic Colon				
Blood in Your Stool				
Other Gastrointestinal Conditions				
6. LIVER				
Hepatitis				
Other Liver Conditions				
7. UROGENITAL				
Kidney Stones				
Difficult, Painful, Frequent Urination				
Blood in Urine				
Urinary Tract Infection				
Prostate Infection				
Hernia; If Yes, Location: ___________________________________				
Breast Pain, Lumps, or Discharge				
MALES: Vasectomy				
FEMALES:				
Date of Last Menstrual Period _______________				
Irregular or Painful Menstrual Periods				
Form of Birth Control				
Surgically Sterile: Hysterectomy/Tubal Ligation				
Post-Menopausal				
Other Urogenital Conditions				
If Yes, Describe:				

Check “YES” for anything that has been diagnosed, treated, or is a recurring problem:	YES	NO	Date of Onset	✓ if Cont.
8. NEUROLOGICAL				
Epilepsy or Seizures				
Fainting Spells				
Headaches (Stress, Migraine, Sinus, etc.)				
Other Neurological Conditions				
9. HEMATOLOGICAL (Blood)				
Anemia or Bleeding Problems				
Leukemia				
Frequent Blood/Plasma Donor				
Transfusions				
Enlarged Lymph Nodes or Persistent Lumps				
Other Blood Conditions				
10. ENDOCRINE (Glands)				
Thyroid Problems				
Diabetes				
Other Endocrine Conditions				
11. MUSCULOSKELETAL				
Arthritis or Joint Problems				
Recurrent Back or Neck Pain				
Noncancerous Tumor/Cyst				
Tendonitis/Bursitis				
Other Musculoskeletal Conditions				
12. SKIN				
Dermatitis or Skin Problems				
Persistent Rash or Hives				
Other Skin Conditions				

Check "YES" for anything that has been diagnosed, treated, or is a recurring problem:	YES	NO	Date of Onset	✓ if Cont.
13. PSYCHIATRIC				
Trouble Sleeping or Insomnia				
Depression				
"Nervousness"				
Other Psychological or Emotional Problems				
Unexplained Weight Change Greater than 10 lbs.				
14. OTHER:				
Alcohol				
If Yes, specify: Amount per day: _______; Year stopped: _______; or continuing:______				
Tobacco Use				
If Yes, specify: Year started: ______; Packs per day: ______; Year stopped:______; or continuing: ______ Pack years smoked: _____ (1 pack year equals 1 pack of cigarettes smoked per day during 1 year)				
Illicit Drugs				
If Yes, specify: Year started:______ Year stopped: _______; or continuing:_______ Usage: Heavy_____ Moderate ____ Light/infrequent _____				
Exercise Program				
Special Diet				
Cancer				

HOSPITALIZATIONS AND SURGERIES (In-Patient and Out-Patient)

Description	Date

Additional Comments

MEDICATIONS TAKEN WITHIN THE PAST 90 DAYS

(Include drops, topical, vitamins, and all other prescription or over the counter medications)

Medication	Dose/Frequency	Date Started	Date Stopped	Indication

Primary Physician:

Name: ____

Address: ____

REVIEWED WITH PATIENT BY: ______________________________ **DATE:** __________

PATIENT SIGNATURE: ___________________________________ **DATE:** __________

INVESTIGATOR SIGNATURE: _______________________________ **DATE:** __________