PATIENT HISTORY QUESTIONNAIRE

Instructions: Please fill out the form, mail it or bring to your next appointment. Note that your health information is private and will be stored in a secured electronic medical record.

Name_____: DOB: _____ DATE: _____

Home Phone: _____ Office Phone_____ Cell Phone_____

Preferred method of Contact: PHONE MAIL EMAIL

Email Address: _____

Mailing Address: _____

Other Physicians

General/Family _____ General Surgeon_____

Cardiologist (heart) _____ Heart Surgeon_____

Pulmonogist (lung) _____ Orthopedic Surgeon_____

Rheumatologist (joints) _____ Ophthalmologist (eye) _____

Endocrinologist_____ Gastroenterologist_____

Neurologist_____ OB/GYN_____

I. Medications (Please list all of your current medications including prescriptions, over-the-counter medications and vitamins and how often you take them) **Always bring all medications to your appointment.**

II. Allergies (Please list allergic/adverse reaction to medication/food/latex gloves/eggs/dyes and reactions you have)

PATIENT HISTORY QUESTIONNAIRE (Cont'd)

Socio-Economic History
What is your occupation?
Years of Education/Highest Degree
Marital Status ___ Single _____Married ____Divorced ____Widowed
Who lives with you at home?
Children ____Yes _____No _____Sons ____Daughters

Check All That Apply To You
History of:

☐	Anxiety	☐	Mononucleosis
☐	Anemia	☐	Nephrolithiasis (Kidney Stones)
☐	Arthritis	☐	Neuromuscular disease
☐	Asthma	☐	Neuropathy
☐	Bleeding Problems	☐	Retinopathy
☐	Broken Bones	☐	Sleep Apnea
☐	CAD (Coronary Artery Disease)	☐	Stroke
☐	Cancer	☐	Thyroid
☐	CHF (Congestive Heart Failure)	☐	UTI(Urinary Tract Infection)
☐	Dentures	☐	
☐	Depression	☐	
☐	Diabetes	☐	
☐	DVT (Deep Vein Thrombosis)	☐	
☐	Eye Disease	☐	
☐	Frequent Colds	☐	
☐	GI Disorders	☐	
☐	Gout	☐	
☐	Hearing Problems	☐	
☐	Hepatitis	☐	
☐	High Blood Pressure	☐	
☐	MI (Myocardial Infarction/Heart Attack)	☐	

III. Health Maintenance/Preventative Healthcare

Colon Screening
Have you had a colonoscopy ___ Yes ___No Date: _____

Women
Date of Last Mammogram: _____

Men
Date of Last Prostate Exam _____
Date of last PSA_____

PATIENT HISTORY QUESTIONNAIRE (Cont'd)

Immunizations/Tests for Adults/Dates
Flu Vaccine
Pneumovax
Tetanus/Diphtheria/Pertussis
Hepatitis B Vaccine
Zostervax (shingles)

IV. Social History
Tobacco Use __ Never Quit____ Date_____
If you are a smoker how many packs/day_____
How long have you smoked _____
Do you smoke __Pipe __ Cigar __ Snuff __Chewing Tobacco
Have you ever had a transfusions _____ Yes ____ No Date_____

Alcohol Usage
Do you drink alcohol ___Yes ___ No
Type of Alcohol _____
Number of drinks/week _____
Alcohol problems in the past____ Yes _____No

Drug Use
Do you use any recreational or illegal drugs _____Yes ____ No
Have you ever used needles to inject drugs _____Yes ____ No
Type of illegal or injectable drugs_____

Sexual History
Have you ever had a sexually transmitted disease _____Yes ____ No

V. Family History
Please check significant medical conditions among your BLOOD relatives

☐ Anemia	☐
☐ Cancer	☐
☐ Coronary Artery Disease (CAD)	☐
☐ Diabetes Mellitus	☐
☐ Heart Disease	☐
☐ Hyperlipidemia	☐
☐ Hypertension	☐
☐ Kidney Disease	☐
☐ Kidney Stones	☐
☐ Strokes	☐
☐	☐
☐	☐

PATIENT HISTORY QUESTIONNAIRE (Cont'd)

VI. Previous Hospitalizations (Please list previous hospitalizations during the last 2 years including the reason and the date)

Previous Surgical History (Please list all surgeries, date and surgeon)