



Medical History Questionnaire

Primary physician: _____

Referring physician: _____

Last Name: _____

First Name: _____

Age: _____ DOB: ____/____/____ Male Female

Height: _____ Weight: _____ lbs

Reason for visit today: _____

Preferred Pharmacy	Preferred Lab	Allergies
Name: _____ Location: _____ Tel #: _____	<input type="checkbox"/> Quest <input type="checkbox"/> Labcorp <input type="checkbox"/> Shiel <input type="checkbox"/> Bioreference <input type="checkbox"/> Other: _____	<input type="checkbox"/> No Known Drug Allergies <input type="checkbox"/> 1. _____ <input type="checkbox"/> Soy allergy <input type="checkbox"/> 2. _____ <input type="checkbox"/> Egg allergy <input type="checkbox"/> 3. _____ <input type="checkbox"/> Latex allergy

Current Medications:				
Medication Name	Dose / How often		Medication Name	Dose / How often

Previous Immunizations			
<input type="checkbox"/> None	<input type="checkbox"/> Influenza, date: _____	<input type="checkbox"/> Hepatitis A, date: _____	<input type="checkbox"/> Hepatitis B, date: _____

Previous Diagnostic Tests: please indicate when and where your tests were done:	
<input type="checkbox"/> Endoscopy (EGD) When: _____ Where: _____ Result: _____	<input type="checkbox"/> Colonoscopy When: _____ Where: _____ Result: _____

Past or Present Medical Conditions: please check all that apply.

Cardiac/Heart	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart Failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Chest pain/Angina	<input type="checkbox"/> High cholesterol <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Anticoagulant therapy	<input type="checkbox"/> Cardiac stent <input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator <input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Heart murmur <input type="checkbox"/> Blood Clot/DVT <input type="checkbox"/> Other: _____
Pulmonary/Lungs	<input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Lung cancer <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Positive TB test	<input type="checkbox"/> Use CPAP at home <input type="checkbox"/> Use oxygen at home	<input type="checkbox"/> Other: _____ _____
Endocrine	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Other: _____
Renal/Kidney	<input type="checkbox"/> Urinary tract infection <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Kidney failure <input type="checkbox"/> Dialysis		<input type="checkbox"/> Other: _____
Intestinal/Liver	<input type="checkbox"/> Acid reflux <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Barrett's esophagus <input type="checkbox"/> Peptic ulcer <input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Colon cancer <input type="checkbox"/> Colon polyps <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Gallstones <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Fatty Liver <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Other _____ _____ _____
Hematology/Oncology	<input type="checkbox"/> Anemia <input type="checkbox"/> Low iron levels <input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> On chemotherapy <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Taking blood thinner	<input type="checkbox"/> Cancer, type: _____ _____	<input type="checkbox"/> Blood transfusion <input type="checkbox"/> Other _____ _____
Rheumatology	<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus	<input type="checkbox"/> Scleroderma <input type="checkbox"/> Sjogren's	<input type="checkbox"/> Fibromyalgia <input type="checkbox"/> On steroids	<input type="checkbox"/> Other: _____
Mental Health	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	<input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Other: _____
Neurology	<input type="checkbox"/> Stroke <input type="checkbox"/> TIA	<input type="checkbox"/> Seizure/Epilepsy <input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Memory loss <input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Other: _____
Gynecology	<input type="checkbox"/> Last Menstrual Period: _____	<input type="checkbox"/> Post-menopausal	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Tubal ligation
Orthopedic	<input type="checkbox"/> Chronic back pain <input type="checkbox"/> Herniated disc	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Fractures: _____	<input type="checkbox"/> Other: _____

Previous Surgeries:	<input type="checkbox"/> No prior surgeries		
<input type="checkbox"/> Gallbladder removed, date:	All other surgeries:	Date:	
<input type="checkbox"/> Appendix removed, date:	1.		
<input type="checkbox"/> Colon surgery, date:	2.		
<input type="checkbox"/> Small bowel resection, date:	3.		
<input type="checkbox"/> Gastric lap band, date:	4.		
<input type="checkbox"/> Gastric bypass/sleeve, date:	5.		
<input type="checkbox"/> Hysterectomy, date:	7.		
<input type="checkbox"/> Caesarian section, date(s):	8.		
<input type="checkbox"/> Heart bypass surgery, date:	9.		
<input type="checkbox"/> Heart valve surgery, date:	10.		

Social History	
General	Occupation: _____ <input type="checkbox"/> Retired
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union
Alcohol Use	<input type="checkbox"/> None <input type="checkbox"/> Yes: Type _____ Amount _____ How Often: _____
Caffeine Use	<input type="checkbox"/> None <input type="checkbox"/> Coffee: _____ cups/day <input type="checkbox"/> Tea: _____ cups/day <input type="checkbox"/> Soda _____ cans / day
Tobacco Use	<input type="checkbox"/> Never smoked <input type="checkbox"/> Former Smoker, quit _____ years ago <input type="checkbox"/> Current smoker: _____ cigarettes/day <input type="checkbox"/> Pipe / cigar use
Drug Use	<input type="checkbox"/> None <input type="checkbox"/> Cocaine, How often _____ <input type="checkbox"/> Marijuana, How often _____ <input type="checkbox"/> Intravenous drugs, How often _____

Review of Symptoms

Please Check **Yes** or **No** according to your present condition:

	Yes	No		Yes	No		Yes	No
Constitutional			Gastrointestinal			Hematologic/Lymphatic		
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Fever or Chills	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal distension	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Gas/Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Skin		
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Excessive belching	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immunological			Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	New Lesions	<input type="checkbox"/>	<input type="checkbox"/>
HIV Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Regurgitation of food	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic		
Persistent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, lightheaded	<input type="checkbox"/>	<input type="checkbox"/>
Strong Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Fullness after meals	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain / tightness	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with memory	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Black stools	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>
Leg swelling/Edema	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Urinary		
Respiratory			Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Fatty food intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Urination at night	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Lactose intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain	<input type="checkbox"/>	<input type="checkbox"/>	Joints/Muscle		
Painful Respiration	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Backaches	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health			Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Soiling or incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal		
			Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
			Head & Neck			Flushing	<input type="checkbox"/>	<input type="checkbox"/>
			Change in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heat/cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
			Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>			
			Nose/Gum Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
			Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>			
			Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>			
			Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>			

Patient's Signature: _____

Date: _____