Medical History Questionnaire

Name: ____ Date of Birth: ____________________

Previous Primary Care Provider: ________________________ Pharmacy: _______________________

Other Care Team Providers (e.g. Florida provider, specialist): ___________________________________

Height: ______________________ Weight: ______________________________________

Health History Have you had any of the following?

___ Addiction

___ Anxiety/Panic Disorder/PTSD

___ Arthritis

___ Asthma or Shortness of Breath

___ Back or Neck Problems

___ Blood Diseases or Anemia

___ Bowel Diseases or Ulcers

___ Dizziness

___ Fainting

___Headaches

___ Loss of Consciousness

___ Memory Loss

___ Bronchitis or Chronic Cough

___ Cancer or Tumor Location ____________

___ Depression

___ Diabetes

___ Diabetes

___ Emphysema

___ Fractures Bone/Joint Deformities

___ Gout

___ Eye Trouble, Injury or Blindness

___ High Cholesterol

___ Seizures

___ Joint Problems

___ Hernia

___ Gynecological Problems

___ Hearing Loss/Ringing in Ears

___ Heart Disease or Chest Pain

___ High Blood Pressure

___ Prostate Trouble

___ Liver Disease or Hepatitis

___ Neurological Problems

___ Skin Disease

___ Tuberculosis

___ Trouble Sleeping

___ Thyroid Trouble

___ Other ______________________________

____

____

____

____

____

Health Screening — Date of Last Exam:

Colonoscopy: __________________ PSA: __________________ Pap Smear: _________________

Mammogram: _________________ Last Menstrual Period: ___________________________________

Surgical History

Date:	Surgery	Date	Surgery
________	_________________________________	________	____________________________
________	_________________________________	________	____________________________

Family History

___ I am adopted and do not know my family history.

Father	Mother	Sibling	Child	Medical Problem
				Cancer or Tumor
				Diabetes
				High Blood Pressure
				Heart Disease or Heart Attack
				Mental Health
				Substance Abuse
				Other

Father Deceased: Yes/No If yes, Cause and Date of Death:______________________

Mother Deceased: Yes/No If yes, Cause and Date of Death:______________________

Social History

Alcohol Use: Yes/No Amount: __________

Drug Use: Yes/No

Smoking: Yes/No

Former Smoker: Yes/No If yes, estimated quit date: ________________

Chewing Tobacco: Yes/No

Abuse/Neglect: Yes/No

Employed: Yes/No If yes, occupation: _______________________

Occupational Injury: Yes/No If yes, explain: __________________________

Retired: Yes/No

Living with Spouse: Yes/No

Living Alone: Yes/No

Allergies

Medication Allergies/Reaction	**Food, Environmental, Animal Allergies/Reaction**
_________________________	____
_________________________	____
_________________________	____

Current Medications

Medication & Dosage	**Frequency/Times Per Day**
_______________________________	_____________________
_______________________________	_____________________
_______________________________	_____________________
_______________________________	_____________________
_______________________________	_____________________

Immunization History

Date of last Tetanus Shot: ________________ If unknown, was it within the last 10 years? Yes/No

Have you ever received the pneumovax pneumonia vaccine? Yes/No If yes, Date: _________