MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date of Birth_____

Primary Doctor _____ Date _____

What brings you to the office today?

_____
_____
_____
_____

Please list all the medications you take. Include all vitamins and other over-the-counter medications. (Example: aspirin, 325 mg, one a day)

_____
_____
_____
_____

Have you had any x-rays or procedures done in the past 3 months where you were given contrast? _____

Do you have, or have you had, any of the following medical conditions?

	Yes	No	
Eye disease	☐	☐	_____
Pituitary problems	☐	☐	_____
Thyroid problems	☐	☐	_____
Head/neck irradiation	☐	☐	_____
Diabetes	☐	☐	_____
Heart problems	☐	☐	_____
Cholesterol problems	☐	☐	_____
High blood pressure	☐	☐	_____
Stroke	☐	☐	_____
Lung problems	☐	☐	_____
Bowel disease	☐	☐	_____
Heartburn/Reflux Gallstones	☐	☐	_____

(continued on back)

	Yes	No	
Kidney problems/ Stones adrenal problems	☐	☐	_____
Arthritis	☐	☐	_____
Tuberculosis	☐	☐	_____
Cancer	☐	☐	_____
Anemia (low blood count)	☐	☐	_____
Skin disorders	☐	☐	_____
Surgeries	☐	☐	_____

_____

_____

_____

Do your family members have, or have they had, any of the following medical conditions? (parents, siblings, children)

	Yes	No	Relationship to patient
Eye disease	☐	☐	_____
Pituitary problems	☐	☐	_____
Thyroid problems	☐	☐	_____
Diabetes	☐	☐	_____
Heart problems	☐	☐	_____
Cholesterol problems	☐	☐	_____
High blood pressure	☐	☐	_____
Stroke	☐	☐	_____
Lung problems	☐	☐	_____
Bowel disease	☐	☐	_____
Kidney problems/stones	☐	☐	_____
Adrenal problems	☐	☐	_____
Arthritis	☐	☐	_____
Tuberculosis	☐	☐	_____
Cancer	☐	☐	_____
Anemia (low blood count)	☐	☐	_____
Skin disorders	☐	☐	_____
Other	☐	☐	_____

_____

_____

_____

_____

(continued on next page)

Name _____

What is your occupation? _____

How much alcohol do you drink? _____

How much do you smoke? _____

How many children do you have? _____

Do you <u>currently</u> have any of the following complaints?

	Yes	No	
Change in appetite	☐	☐	_____
Change in weight	☐	☐	_____
Fever	☐	☐	_____
Chills	☐	☐	_____
Night sweats	☐	☐	_____
Change in energy	☐	☐	_____
Headaches	☐	☐	_____
Blurry vision	☐	☐	_____
Double vision	☐	☐	_____
Loss of vision	☐	☐	_____
Other change in eyes	☐	☐	_____
Congestion	☐	☐	_____
Sore throat	☐	☐	_____
Lesions in mouth	☐	☐	_____
Difficulty swallowing	☐	☐	_____
Hoarseness/change in voice	☐	☐	_____
Cough	☐	☐	_____
Shortness of breath	☐	☐	_____
Chest pain	☐	☐	_____
Fast/irregular heartbeats	☐	☐	_____
Dizziness	☐	☐	_____
Sweating	☐	☐	_____
Swelling	☐	☐	_____
Nausea	☐	☐	_____
Vomiting	☐	☐	_____
Stomach pain	☐	☐	_____
Diarrhea	☐	☐	_____
Constipation	☐	☐	_____

(continued on back)

	Yes	No	
Other change in bowels	☐	☐	_____
Excessive thirst	☐	☐	_____
Excessive urination	☐	☐	_____
Up during night to urinate	☐	☐	_____
Yeast infections	☐	☐	_____
Discharge from breasts	☐	☐	_____
Enlargement of breasts	☐	☐	_____
Change in libido	☐	☐	_____
Problems with erections	☐	☐	_____
Change in ring/shoe/hat size	☐	☐	_____
New spacing of teeth	☐	☐	_____
Easy bruising	☐	☐	_____
Tremors/shaking of hands	☐	☐	_____
Numbness or tingling	☐	☐	_____
Feel hot/cold most of time	☐	☐	_____
Muscle aches	☐	☐	_____
Joint aches	☐	☐	_____
Weakness	☐	☐	_____
Change in moods	☐	☐	_____
Irritability	☐	☐	_____
Change in memory	☐	☐	_____
Problems concentrating	☐	☐	_____
Change in skin	☐	☐	_____
Acne	☐	☐	_____
Change in hair	☐	☐	_____
Excessive hair growth	☐	☐	_____
Other	☐	☐	_____

FOR WOMEN:

At what age did you start having menstrual periods? _____

When was your last menstrual period? _____

Has there been any change in your periods? _____

_____

_____

_____

How many times have you been pregnant?

_____