# MEDICAL QUESTIONNAIRE

| | | |
|---|---|---|
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**Patient Name:** _____ **Today's Date:**_____ **Birthdate:** _____

**Age:**_____ **Sex:** ____**Female** ____**Male**

**Who is your family doctor?** _____

**Please list name and address of the pharmacy you use:** _____

**What is the reason for your visit? Please list chief complaints:** _____
_____.

**PLEASE ( X ) SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.**

| **GENERAL** | | **GENITO-URINARY** | | **CARDIOVASCULAR** | | **SKIN** | |
|---|---|---|---|---|---|---|---|
| Chills | | Blood in urine | | Chest pain | | Bruise easily | |
| Depression | | Frequent urination | | High blood pressure | | Hives | |
| Dizziness | | Lack of bladder control | | Irregular heart beat | | Itching | |
| Fainting | | Painful urination | | Low blood pressure | | Change in moles | |
| Fever | | **GASTROINTESTINAL** | | Poor circulation | | Rash | |
| Forgetfulness | | Appetite poor | | Rapid heart beat | | Sore that won't heal | |
| Headache | | Bloating | | Swollen feet/ankles | | Anemia | |
| Loss of sleep | | Bowel Changes | | Varicose veins | | **MEN ONLY** | |
| Nervousness | | Constipation | | **EYE, EAR, NOSE and THROAT** | | Breast lump | |
| Numbness | | Diarrhea | | Bleeding gums | | Erection difficulties | |
| Sweats | | Excessive hunger | | Blurred vision | | Lump in testicles | |
| Weight loss | | Excessive thirst | | Difficulty swallowing | | Other | |
| **MUSCLE** | | Gas | | Double vision | | | |
| **JOINT/BONE** | | Hemorrhoids | | Earache | | **WOMEN ONLY** | |
| Pain, weakness, Or numbness in: | | Indigestion | | Hay fever | | Abnormal pap smear | |
| Arms | | Nausea or Vomiting | | Hoarseness | | Bleeding between periods | |
| Hands | | Rectal bleeding | | Loss of hearing | | Extreme menstrual pain | |
| Back | | Abdominal/stomach pain | | Nosebleeds | | Hot flashes | |
| Feet | | Vomiting blood | | Persistent cough | | Painful intercourse | |
| Hips | | **RESPIRATORY** | | Ringing in the ears | | Vaginal discharge | |
| Legs | | Cough w/phlegm? Dry? | | Sinus problems | | Other | |
| Neck | | Shortness of breath | | Vision-Flashes/Halos | | | |
| Shoulders | | Wheezing | | | | | |

**PLEASE ( X ) CONDITIONS YOU HAVE OR HAD IN THE PAST.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS | | Chemical Dependency | | High Cholesterol | | Prostrate Problems | |
| Alcoholism | | Chicken Pox | | HIV Positive | | Psychiatric Care | |
| Anemia | | Diabetes | | Kidney Disease | | Rheumatic Fever | |
| Anorexia | | Emphysema | | Liver Disease | | Scarlet Fever | |
| Appendicitis | | Epilepsy | | Measles | | Stroke | |
| Arthritis | | Glaucoma | | Migraine Headaches | | Suicide Attempt | |
| Asthma | | Goiter | | Miscarriage | | Thyroid Problems | |
| Bleeding Disorder | | Gonorrhea | | Mononucleosis | | Tonsillitis | |
| Breast Lump | | Gout | | Multiple Sclerosis | | Tuberculosis | |
| Bronchitis | | Heart Disease | | Mumps | | Typhoid Fever | |
| Bulimia | | Hepatitis | | Pacemaker | | Ulcers | |
| Cancer | | Hernia | | Pneumonia | | Vaginal infections | |
| Cataracts | | Herpes | | Polio | | Venereal disease | |

**Please list any medications you are now taking. Be sure to indicate the dosage and frequency:**

**Do you have any ALLERGIES to medications?** ____**NO** _____**YES**
**If yes, list the drug(s) and describe the reaction:**

**HEALTH HABITS: Check (x) which substances you use and describe how much you use:**

__ **Caffeine/How much** _____ ___**Tobacco/How much** _____

__**Drugs/How much** _____ ___ **Alcohol** _____

**Have you ever had a blood transfusion?** ____ **NO** ____ **Yes (Give approximate date** _____**)**

******MEDICAL HISTORY******

| YEAR | TYPE OF MEDICAL PROBLEM | TREATMENT | DOCTOR | HOSPITALIZED? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

******PAST SURGERY (OPERATIONS) – Please list in order**

| YEAR | TYPE OF OPERATION | REASON FOR SURGERY | DOCTOR | HOSPITAL |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

******RADIATION THERAPY PATIENTS******

| STARTED? MONTH/YEAR | STOPPED? MONTH/YEAR | AREA OF BODY TREATED | DOCTOR | HOSPITAL OR FACILITY |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

******FAMILY HISTORY******

| RELATION | AGE | STATE OF HEALTH | AGE OF DEATH | CAUSE OF DEATH |
|---|---|---|---|---|
| FATHER | | | | |
| MOTHER | | | | |
| BROTHERS | | | | |
| SISTERS | | | | |

**Check (x) if you or your blood relatives had any of the following:**

| | Disease | You | Relationship to you |
|---|---|---|---|
| ☐ | Breast Cancer | ☐ | |
| ☐ | Ovarian Cancer | ☐ | |
| ☐ | Other Cancers/List below | ☐ | |
| ☐ | Diabetes | ☐ | |
| ☐ | Heart Disease or stroke | ☐ | |
| ☐ | High Blood Pressure | ☐ | |
| ☐ | Kidney Disease | ☐ | |
| ☐ | Tuberculosis | ☐ | |
| ☐ | Family history of other diseases:<br>List Below: | ☐ | |

*******WOMEN ONLY*******

**Breast Health History:**

**Past breast problems (list):** _____

**Last mammogram: Date:** _____ **Where:** _____

**Are you now taking hormones or birth control pills?** ☐ **NO** ☐ **YES**

**Have you ever taken birth control pills or hormones?** ☐ **NO** ☐ **YES** **TYPE:** _____

**HOW LONG?** _____ **WHEN STOPPED?** _____

**Do you perform self-breast exams?** ☐ **NO** ☐ **YES** **Frequency?** _____

**Age at onset of periods:** _____ **Number of pregnancies:** _____

**Number of births:** _____

**Number of abortions:** _____

**Age at first childbirth:** _____

**Have you gone through menopause?** ☐ **NO** ☐ **YES**

**Are you pregnant?** ☐ **NO** ☐ **YES**