Patient Name: _____ DOB: _____

PATIENT HISTORY QUESTIONNAIRE

1. *PAST MEDICAL HISTORY*:

- ☐ Abnormal PAP Smear
- ☐ Allergies- indicate type/reaction _____ _____ _____
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disorder
- ☐ Bladder/Kidney Problems
- ☐ Blood Clots
- ☐ Blood Transfusions
- ☐ Cancer- indicate type _____
- ☐ Colon Polyps
- ☐ Cerebrovascular Disease
- ☐ Cirrhosis
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes – Type ____
- ☐ Emphysema (COPD)
- ☐ GERD/ Heartburn
- ☐ GI Bleed
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hemochromatosis
- ☐ Hepatitis _____
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Migraine Headaches
- ☐ Neurologic Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Seizure Disorder
- ☐ Skin Conditions
- ☐ Sleep Apnea
- ☐ Stroke(s)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ UTI- Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

2. *PAST PROCEDURE AND SURGICAL HISTORY: (indicate date)*

- ☐ Appendectomy _____
- ☐ Back Surgery _____
- ☐ Breast Surgery _____
- ☐ Colonoscopy _____
- ☐ Coronary Artery Bypass _____
- ☐ Coronary Stent _____
- ☐ Gall Bladder Removal _____
- ☐ Hip Surgery _____
- ☐ Hysterectomy (partial) _____
- ☐ Hysterectomy (total) _____
- ☐ Knee Surgery _____
- ☐ Mastectomy _____
- ☐ Mammogram _____
- ☐ Neck Surgery _____
- ☐ Pulmonary Function _____
- ☐ Sigmoidoscopy _____
- ☐ Stress Test _____
- ☐ Tonsillectomy _____
- ☐ Vasectomy _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

ADDITIONAL HISTORY: (indicate date)

□ A1c (if diabetic) _____ □ Flu Vaccine _____ □ Pneumonia Vaccine _____

□ Shingles Vaccine _____ □ Tetanus Vaccine _____

3. ***FAMILY HISORY:*** *Please check type of disease. Include relation, age at onset, cause of death*

I.e.: Check heart attack—mother, onset 50 y/o, death 53 y/o- cause

□ Alcoholism _____

□ Alzheimer's/Dementia _____

□ Autoimmune Disease (indicate type) _____

□ Cancer (indicate type) _____

□ Depression _____

□ Diabetes (indicate type) _____

□ Drug Use (indicate type) _____

□ Heart Disease (indicate type) _____

□ Hepatitis (indicate type) _____

□ Hypertension _____

□ Osteoporosis _____

□ Other _____

4. ***SOCIAL HISTORY: Please check***

Marital Status	**Nicotine Use**	**Alcohol or Drug Use**	**Exercise**
□Single	□Current Smoker	□Yes	□ Never
□Married	Age started: _____	Type: _____	□ 1-3 times per week
□Divorced	# Per day: _____	# Per Day: _____	□ 4+ times per week
□Separated	Type: _____	□No	
□Widowed	□Former Smoker		
	Age stopped: _____		
	Type: _____		
	□Never Smoked		

Are you currently under the care of a specialist? □No □Yes

If yes, please provide name: _____

_____