Past Medical History Questionnaire

Name: _____ Date: _____

CONDITIONS - Check conditions which you have now or had in the past

❑ anemia	❑ heart disease	❑ pacemaker
❑ asthma	❑ hepatitis	❑ pneumonia
❑ bleeding disorder	❑ high blood pressure	❑ polio
❑ cancer (area:_____)	❑ high cholesterol	❑ rheumatic fever
❑ diabetes	❑ HIV positive or AIDS	❑ rheumatoid arthritis
❑ emphysema	❑ kidney disease	❑ stroke
❑ epilepsy	❑ lupus	❑ thyroid disease
❑ glaucoma	❑ multiple sclerosis	❑ tuberculosis
❑ gout	❑ osteoporosis	❑ ulcers

OPERATIONS: ❑ None ❑ See separate list

Surgery	Year

MEDICATIONS: ❑ None ❑ See separate list

Medicine	Dose

ALLERGIES TO MEDICATIONS ❑ None

Medication	Reaction

DOMINANT HAND: ❑ right ❑ left ❑ ambidextrous

MAR. STATUS: ❑ married ❑ single ❑ divorced ❑ widow(er)

HABITS: ❑ tobacco ❑ alcohol ❑ recreational drugs ❑ none
Specify (type, quantity):

OCCUPATION:

Diseases that run in your family: ❑ arthritis ❑ cancer ❑ diabetes ❑ heart disease ❑ high blood pressure ❑ strokes ❑ other:

SYMPTOMS – Check any symptoms you have experienced recently

Constitutional: ❑ unexpected weight loss ❑ unexpected weight gain ❑ fever ❑ chills ❑ fatigue

Eyes: ❑ corrective lenses ❑ blurred/double vision ❑ eye pain ❑ redness ❑ watering

ENT: ❑ headache ❑ hoarseness ❑ nose bleeds ❑ ringing in ears ❑ earache ❑ hearing loss ❑ vertigo

Cardiovascular: ❑ chest pain ❑ palpitations ❑ fainting ❑ heart murmur ❑ ankle swelling ❑ varicose veins

Respiratory: ❑ shortness of breath ❑ wheezing ❑ cough ❑ chest tightness ❑ pain when breathing ❑ snoring

Gastrointestinal: ❑ heartburn ❑ nausea ❑ vomiting ❑ constipation ❑ diarrhea ❑ bloody stools

Urological: ❑ frequent urination ❑ painful urination ❑ urgency ❑ flank pain ❑ blood in urine

Musculoskeletal: ❑ joint pains ❑ swelling ❑ instability ❑ stiffness ❑ redness ❑ heat ❑ muscle pain

Skin: ❑ skin changes ❑ poor healing ❑ rash ❑ itching ❑ redness

Neurologic: ❑ numbness/tingling ❑ unsteady gait ❑ dizziness ❑ tremors ❑ seizure ❑ poor memory

Psychiatric: ❑ nervousness ❑ anxiety ❑ depression ❑ hallucinations ❑ insomnia

Hematologic: ❑ easy bruising ❑ easy bleeding

Endocrine: ❑ excessive thirst ❑ excessive urination ❑ heat intolerance ❑ cold intolerance

Allergic: ❑ reaction to foods or environment (specify): _____

My signature below indicates that my answers to this health history are accurate and complete to the best of my knowledge.

Signature: _____ Date: _____