MEDICAL HISTORY QUESTIONEER

*Name*_____ *DOB:* _____ *Date* _____

REASON FOR TODAYS VISIT

_____

_____

***ALLERGIES**:* _____

_____

PATIENT HISTORY (PLEASE CIRCLE YES OR NO)

HIGH BLOOD PRESSURE	*YES NO*	
CORONARY ARTERY DISEASE	*YES NO*	
DIABETES	*YES NO*	
HIGH CHOLESTEROL	*YES NO*	
CONGESTIVE HEART FAILURE	*YES NO*	
POOR CIRCULATION	*YES NO*	
PACEMAKER OR ICD	*YES NO*	*IF YES: DATE*_____
HEART ATTACK	*YES NO*	
SMOKER	*YES NO*	*IF YES: PACKS PER DAY* _____
COUGH	*YES NO*	
SHORTNESS OF BREATH	*YES NO*	
WHEEZING	*YES NO*	
BLOOD IN URINE	*YES NO*	
DIFFICULTY URINATING	*YES NO*	
NAUSEA	*YES NO*	
VOMITTING	*YES NO*	
DIARRHEA	*YES NO*	
CONSTIPATION	*YES NO*	
SKIN RASH	*YES NO*	
SWELLING	*YES NO*	
RECENT WEIGHT LOSS	*YES NO*	
FEVER	*YES NO*	

FAMILY MEMBER	*STILL LIVING*	*AGE*	*HEALTH CONDITION*
FATHER	*YES / NO*	_____	_____
MOTHER	*YES / NO*	_____	_____
SISTER	*YES / NO*	_____	_____
SISTER	*YES / NO*	_____	_____
BROTHER	*YES / NO*	_____	_____
BROTHER	*YES / NO*	_____	_____

*Name*_____ *DOB:* _____ Date _____

LIST SURGERIES

DATE *REASON*

LIST HOSPITALIZATIONS

DATE *REASON*

MAINTENANCE MEDICATIONS