



## Medical History Questionnaire

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*Please complete the following as accurately as possible.*

Name: **X** \_\_\_\_\_

Date: \_\_\_\_ \_\_\_\_ \_\_\_\_

### Present Illness:

What is your chief complaint?

When did this condition begin?

What treatment have you received already?

### Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking?

### Have any of your blood relatives had any of the following?

- Stroke
- Cancer
- Heart Disease
- Tuberculosis
- Bleeding disorders
- Diabetes
- High blood pressure

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*Please complete the following as accurately as possible.*

Indicate if you have had any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Cold sores                             | <input type="checkbox"/> Hemorrhoids                             |
| <input type="checkbox"/> Genital herpes                         | <input type="checkbox"/> Sexually transmitted diseases           |
| <input type="checkbox"/> Epstein Barr virus (EBV)               | <input type="checkbox"/> Disorder of the genitals                |
| <input type="checkbox"/> Fibromyalgia                           | <input type="checkbox"/> Gynecological disorder                  |
| <input type="checkbox"/> Heart disease                          | <input type="checkbox"/> Congenital abnormalities                |
| <input type="checkbox"/> Rheumatic fever                        | <input type="checkbox"/> Skin diseases                           |
| <input type="checkbox"/> High blood pressure                    | <input type="checkbox"/> Cardiac pacemaker                       |
| <input type="checkbox"/> Stroke                                 | <input type="checkbox"/> Surgical implants                       |
| <input type="checkbox"/> Epilepsy or convulsions                | <input type="checkbox"/> Change in bowel or bladder habits       |
| <input type="checkbox"/> Kidney disease                         | <input type="checkbox"/> Sores that will not heal                |
| <input type="checkbox"/> Urinary bladder problems or infections | <input type="checkbox"/> Unusual bleeding or discharge           |
| <input type="checkbox"/> Diabetes mellitus                      | <input type="checkbox"/> Indigestion                             |
| <input type="checkbox"/> Cancer                                 | <input type="checkbox"/> Colitis                                 |
| <input type="checkbox"/> Respiratory                            | <input type="checkbox"/> Crohn's disease                         |
| <input type="checkbox"/> Pneumonia                              | <input type="checkbox"/> Irritable bowel disease                 |
| <input type="checkbox"/> Emphysema                              | <input type="checkbox"/> Gall stones                             |
| <input type="checkbox"/> Tuberculosis                           | <input type="checkbox"/> Lupus erythmatosus                      |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Difficulty swallowing                   |
| <input type="checkbox"/> Hepatitis                              | <input type="checkbox"/> Obvious change in a wart or mole        |
| <input type="checkbox"/> Peptic ulcer                           | <input type="checkbox"/> Cough                                   |
| <input type="checkbox"/> Pancreatitis                           | <input type="checkbox"/> Hoarseness                              |
| <input type="checkbox"/> Anemia or other blood disorder         | <input type="checkbox"/> History of smoking                      |
| <input type="checkbox"/> Bleeding disorder                      | <input type="checkbox"/> History of smokeless tobacco use        |
| <input type="checkbox"/> Hepatitis                              | <input type="checkbox"/> History of drinking alcohol             |
| <input type="checkbox"/> Jaundice                               | <input type="checkbox"/> History of recreational drug use        |
| <input type="checkbox"/> Hernia                                 | <input type="checkbox"/> History of sexually transmitted disease |
| <input type="checkbox"/> Thyroid disorder                       | <input type="checkbox"/> HIV/ AIDS                               |

**For Women Only:**

Menstrual History:

- Age of your first period: \_\_\_\_\_  
Vaginal discharge: \_\_\_\_\_  
Length of cycle, day 1 to day 1 \_\_\_\_\_  
Length of flow (days): \_\_\_\_\_  
Date of your last period: \_\_\_\_\_  
Do you believe you are pregnant? Yes No

Do you have any of the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Menstrual cramps      | <input type="checkbox"/> Breast pain                                 |
| <input type="checkbox"/> Menstrual blood clots | <input type="checkbox"/> Breast cysts                                |
| <input type="checkbox"/> Excessive bleeding    | <input type="checkbox"/> Emotional changes with period               |
| <input type="checkbox"/> PMS                   | <input type="checkbox"/> Hot flashes                                 |
| <input type="checkbox"/> Breast swelling       | <input type="checkbox"/> Vaginal yeast ( <i>Candida</i> ) infections |

**For Men Only:**

Urology History:

- |  |  |
|--|--|
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Infertility       |
| <input type="checkbox"/> Impotence             | <input type="checkbox"/> Prostate problems |