Medical History Questionnaire

Responses are Optional

Name: _____ **Date of birth:** _____ **Today's Date:** _____

Reason for seeking medical attention: _____

I was referred to this office by: _____

Other doctors involved in my care: _____

Personal Medical History: Have you ever been diagnosed with the following? (Please select)

Cardiovascular:
- ☐ murmur
- ☐ angina/coronary artery disease
- ☐ congestive heart failure
- ☐ rheumatic fever
- ☐ bypass surgery
- ☐ valve replacement
- ☐ irregular heartbeat
- ☐ heart attack
- ☐ aneurysms_____ (type)
- ☐ peripheral arterial disease
- ☐ cardiac disease
- ☐ stroke
- ☐ carotid disease
- ☐ deep venous thrombosis (DVT)
- ☐ thrombophlebitis
- ☐ irregular bleeding

Infectious Disease:
- ☐ AIDS or HIV positive
- ☐ tuberculosis
- ☐ sexually transmitted disease
- ☐ MRSA infection

Gynecological:
- ☐ endometriosis
- ☐ fibroids
- ☐ cysts
- ☐ irregular bleeding
- ☐ pelvic pain with periods
- ☐ pain with intercourse

Musculoskeletal:
- ☐ rheumatoid arthritis
- ☐ osteoarthritis
- ☐ gout
- ☐ fibromyalgia

Respiratory:
- ☐ emphysema/COPD
- ☐ asthma
- ☐ allergies/hayfever
- ☐ chronic bronchitis
- ☐ pneumonia
- ☐ asbestos exposure
- ☐ sleep apnea

Gastrointestinal:
- ☐ ulcers
- ☐ polyps
- ☐ gallstones
- ☐ hiatal hernia
- ☐ hemorrhoids
- ☐ irritable bowel syndrome
- ☐ colitis
- ☐ diverticulosis
- ☐ gastrointestinal bleeding
- ☐ anal fistula
- ☐ anal fissure
- ☐ inflammatory bowel disease (corhon'sulcerative colitis)
- ☐ rectal prolapse

Kidney/Bladder:
- ☐ stones
- ☐ prostate disorder
- ☐ incontinence
- ☐ infection
- ☐ kidney failure

General:
- ☐ high blood pressure
- ☐ diabetes
- ☐ high cholesterol
- ☐ obesity
- ☐ migraines/headaches
- ☐ anemia
- ☐ thyroid problem
- ☐ seizure disorder
- ☐ paralysis
- ☐ glaucoma
- ☐ anxiety
- ☐ depression
- ☐ mental illness
- ☐ alcoholism/drug abuse
- ☐ cancer:_____ type
- ☐ blood transfusion if yes, when:_____

No.	Date	Hospitalizations/Operations Serious Illness or Injuries
1.		
2.		
3.		
4.		

No.	Date	Hospitalizations/Operations Serious Illness or Injuries
5.		
6.		
7.		
8.		

Present Medications: (include birth control pills and non-prescription items such as vitamins, aspirin, herbs, etc.)

No.		Dose	Times/Day
1.			
2.			
3.			
4.			
5.			

No.	Name	Dose	Times/Day
6.			
7.			
8.			
9.			
10.			

Drug Allergies

No.	Medication	Type of Reaction
1.		
2.		
3.		

No.	Medication	Type of Reaction
4.		
5.		
6.		

Medical History Questionnaire

Responses are Optional

Name: _____ **Date of birth:** _____

Social History:

Occupation: _____ Former Regions of Residence: _____

Current Marital Status: (select) ☐ S ☐ M ☐ W ☐ D

Living Situation: (select) ☐ Alone ☐ Roommate ☐ Spouse ☐ Parents ☐ Significant Other ☐ With Children

Do you wear a seat belt? ☐ Yes ☐ No Do you feel safe in your home? ☐ Yes ☐ No

Preventative Health Status:

Date of last physical exam: _____ Last eye exam: _____ Last dental exam: _____

Do you exercise regularly? ☐ Yes ☐ No Type: _____ How often? _____

Do you follow a special diet? ☐ Yes ☐ No Please describe: _____

Do you use tobacco? ☐ Yes ☐ No How much/how long? _____ Quit/When: _____

Do you use Cannabis? ☐ Yes ☐ No How much/how long? _____ Quit/When: _____

Do you drink alcohol? ☐ Yes ☐ No How much per day? _____ Quit/When: _____

Do you drink caffeine? ☐ Yes ☐ No How much per day? _____

Have you used illicit drugs? ☐ Yes ☐ No Which one? _____ Quit/When: _____

Last immunizations: (please give dates if known:)

Tetanus: _____ Pneumonia Vaccine: _____ Flu vaccine _____

TB skin test result: _____ Date: _____ Hepatitis B series: _____ Hepatitis A: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, when? _____

Childhood illness: _____

Major Injuries/date: _____

Have you ever had a colonoscopy? ☐ Yes ☐ No Last colonoscopy date: _____

FOR WOMEN ONLY:

Date of last period: _____ Age periods began: _____ Last Pap: _____ History Abnormal Pap? ☐ Yes ☐ No

Last mammogram: _____ Birth Control Method: _____ Age at start of Menopause: _____

FOR MEN ONLY:

Last PSA or Prostate exam: _____

Family History

Relative	Age if living	Age when deceased	Illnesses/Cause of death
Father			
Mother			
Brothers/Sisters			
Children			

Immediate Family History (select all the apply)

☐ cancer ☐ diabetes ☐ stroke ☐ high cholesterol ☐ aortic aneurysm ☐ bleeding or clotting disorder
☐ ulcers ☐ trouble with anesthesia ☐ tuberculosis ☐ alcohol/substance abuse ☐ migraine headache
☐ depression ☐ asthma/allergies ☐ colon polyps ☐ high blood pressure ☐ arthritis/gout ☐ glaucoma
☐ heart disease ☐ mental illness ☐ thyroid disease ☐ seizures/epilepsy ☐ kidney disease ☐ liver disease
☐ obesity ☐ carotid disease ☐ peripheral arterial disease *(PAD)* ☐ Inflammatory bowel disease *(crohn's ulcerative colitis)*

Other family medical history: _____

Reviewed by Provider: _____ Date: _____

General and Vascular Surgery
Medical History – Review of Systems

Today's Date: _____ **Patient Name:** _____ **Date of Birth:** _____

Review of systems: Check any of the following symptoms you have experienced WITHIN THE PAST YEAR

GENERAL
- ☐ change in heat & cold tolerance
- ☐ persistent fever
- ☐ chills/cold intolerance
- ☐ excess appetite
- ☐ increased thirst
- ☐ lack of appetite
- ☐ night sweats
- ☐ swollen glands
- ☐ unusual weakness
- ☐ unusual fatigue
- ☐ unable to walk 2 flights of stairs
- ☐ weight change
  - ☐ increase _____
  - ☐ decrease _____
- ☐ Other _____
- ☐ **None of the above**

ALLERGY:
- ☐ sneezing
- ☐ environmental allergy
- ☐ food allergy _____
- ☐ Other _____
- ☐ **None of the above**

SKIN:
- ☐ ulcers
- ☐ bruise easily
- ☐ change in skin or mole
- ☐ dryness of skin
- ☐ rash or hives
- ☐ nail change
- ☐ unusual hair loss
- ☐ Other _____
- ☐ **None of the above**

EYES:
- ☐ eye pain
- ☐ blind spells (in one eye)
- ☐ change in vision
- ☐ contact lenses
- ☐ eye infection
- ☐ wear glasses
- ☐ Other _____
- ☐ **None of the above**

EARS/NOSE/THROAT:
- ☐ earache
- ☐ hearing loss
- ☐ ear infection or drainage
- ☐ ringing in ears
- ☐ bleeding gums
- ☐ hoarseness
- ☐ neck swelling/lumps
- ☐ sores in mouth
- ☐ nose bleeds
- ☐ nasal polyps
- ☐ sinus trouble
- ☐ Other _____
- ☐ **None of the above**

BREASTS:
- ☐ discharge/bleeding
- ☐ nipple changes
- ☐ lump
- ☐ pain
- ☐ Other _____
- ☐ **None of the above**

HEART:
- ☐ white, blue or purple discoloration of hands or feet
- ☐ buttock, thigh, calf or foot pain when walking
- ☐ chest discomfort/pain
- ☐ irregular heart beat
- ☐ racing or fluttering heart
- ☐ swollen feet or ankles
- ☐ varicose veins
- ☐ family history of abdominal aortic aneurysm
- ☐ Other _____
- ☐ **None of the above**

LUNGS:
- ☐ shortness of breath
- ☐ persistent cough
- ☐ wheezing
- ☐ cough up blood
- ☐ cough up phlegm
- ☐ difficulty breathing
- ☐ Other _____
- ☐ **None of the above**

BONES AND JOINTS:
- ☐ back or neck pain
- ☐ cramps in muscles
- ☐ painful or stiff joints
- ☐ pain down backs of legs
- ☐ pain in legs with walking
- ☐ swelling in legs
- ☐ redness of joints
- ☐ Other _____
- ☐ **None of the above**

MOOD/MENTAL HEALTH:
- ☐ depressed or sad
- ☐ irritable or angry
- ☐ anxious, tense, or worried
- ☐ fearful
- ☐ sleep problems
- ☐ loss of interest in activities
- ☐ fatigue
- ☐ compulsive behaviors
- ☐ concentration/memory problems
- ☐ stress
- ☐ Other _____
- ☐ **None of the Above**

NEUROLOGIC:
- ☐ coordination problems
- ☐ difficulties in speaking
- ☐ dizziness
- ☐ fainting spells
- ☐ frequent headaches
- ☐ loss of balance
- ☐ loss of sensation
- ☐ muscle weakness
- ☐ numbness or tingling
- ☐ Other _____
- ☐ **None of the above**

Notes:

Reviewed by: _____ Date: _____

Signature: _____

Print Submit