



PATIENT HISTORY QUESTIONNAIRE

Please complete this questionnaire and bring it with you to your appointment.

Name: _____ Date of Birth: _____ Age: _____

Referring Provider: _____ Height: _____ Weight: _____

CHIEF COMPLAINT:

What medical problems would you like us to assist you with today?

PAST MEDICAL HISTORY

Do you have or ever had any of the following?

	Yes	No		Yes	No
Heart Disease or Heart Attack			Gastrointestinal Disorders		
High Blood Pressure			Asthma		
Cancer			Kidney Disease		
Bleeding Problems			Diabetes		
Depression/Anxiety			Liver Disease		
Arthritis			Rheumatic Fever		
Heart Murmur			Tuberculosis		
Other:					

PAST SURGICAL HISTORY

Please list any surgical procedures you have had.

Procedure	Date	Surgeon

Please list any drug allergies you have: _____

FAMILY HISTORY

Does anyone in your family have a history of any of the following?

Table with 6 columns: Condition, Yes (if yes-then who), No, Condition, yes (if yes-then who), No. Rows include Heart Disease, High Blood Pressure, Lung Disease, Cancer, Kidney Disease, Diabetes, Bleeding Disorders, and Other.

SOCIAL HISTORY

Table with 4 columns: Question, Yes, No, If yes, how much?. Rows include Do you smoke?, Are you exposed to passive smoke?, Do you drink alcohol?, and Recent weight change?

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) None

Table with 3 columns: Medication, Dosage, How often taken.

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Cardiovascular:

Coronary Artery Disease
Elevated cholesterol (hyperlipidemia)
High Blood Pressure (hypertension)

Gastrointestinal:

Hepatitis
Hernia
Gastroesophageal Reflux

Genitourinary:

Prostate enlargement (Prostatitis)
Kidney Stones (Nephrolithiasis)
Acute Renal Failure

Ear / Nose / Throat: (HEENT)

Cataracts
Glaucoma
Chronic ear infections (otitis media)
Hearing loss
Sinus problems (chronic sinusitis)
Nasal polyps

Nasal Allergies

Recurrent tonsillitis
Tinnitus
Vertigo

Hematologic:

Anemia

Immunologic:

Allergies Type:
Food allergies Type:
HIV / AIDS

Infectious Disease:

Mononucleosis
STD Type:

Metabolic/endocrine:

Diabetes Type:
Thyroid deficiency (hypothyroidism)
Thyroid excess (hyperthyroidism)

Neoplastic:

Cancer Type:

Neurologic:

Migraine

Obstetric:

Pregnancy Date(s):

Psychiatric:

Adjustment Disorder - Anxiety
Major Depression

Pulmonary:

Asthma
COPD/Emphysema
Sleep Apnea
Tuberculosis

Miscellaneous:

Anesthesia Reaction
Miscellaneous PEDIATRIC
Complications during Pregnancy
Complications during Delivery
NICU stay >48hrs:
Preterm birth

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

SIGNATURE: _____ DATE: _____

THANK YOU

Reviewed by: _____