

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____ **TODAY'S DATE:** _____

What would you like to talk to your doctor about today? _____

MEDICAL HISTORY

Please list any medication allergies or reactions:

Please check to indicate if you have ever had the following conditions:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Diabetes (250.00) | <input type="checkbox"/> High blood pressure (401.9) | <input type="checkbox"/> Asthma (493.20) | <input type="checkbox"/> Heart attack (411.89) |
| <input type="checkbox"/> Kidney disease (588.8) | <input type="checkbox"/> Hepatitis (571.40) | <input type="checkbox"/> Thyroid disease (244.9 hypo; 242.9 hyper) | |
| <input type="checkbox"/> Stroke (436) | <input type="checkbox"/> Depression (311) | <input type="checkbox"/> Emphysema (496) | <input type="checkbox"/> Seizures (345.10) |
| <input type="checkbox"/> Tuberculosis (011.90) | <input type="checkbox"/> Coronary Artery Disease (414.00) | <input type="checkbox"/> Congestive Heart Failure (428.00) | |
| <input type="checkbox"/> Arrhythmia (427.9) | <input type="checkbox"/> Sexually transmitted disease – type: _____ | | |
| <input type="checkbox"/> Eye problems – type: _____ | <input type="checkbox"/> Cancer – type: _____ | | |
| <input type="checkbox"/> Other, please explain: _____ | | | |

Please list any surgeries or hospital stays you have had and their approximate date/year:

<i>Type of surgery / reason for hospitalization / location</i>	<i>Date</i>
_____	_____
_____	_____
_____	_____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

When was your last physical?

Please list all medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Medication Name

Dosage

What pharmacy do you use for prescription medications?

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's name

Condition they are treating you for

Please note dates of your most recent immunizations:

Approximate Date

Approximate Date

Tetanus

Influenza

Pneumonia

Hepatitis B

Other: _____

Other: _____

If you have had any of the following tests done, please note when the tests was done and what the results were, if known:

Test

Approximate Date

Result

Cholesterol

Pap smear/pelvic

Mammogram

Blood in stool

HIV

Colonoscopy

Hepatitis C

FAMILY HISTORY

Check any of the diseases that run in your family **and** please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Other Comments:

HEALTH HABITS

Do you smoke or use any tobacco products?..... ☐ Yes ☐ No ☐ Quit

Number of cigarettes each day? _____

For how many years? _____

Other forms of tobacco used? _____

Do you drink alcohol?..... ☐ Yes ☐ No ☐ Quit

How much? _____

How often? _____

Have you ever felt that you should cut down on your drinking?..... ☐ Yes ☐ No

Have you regularly used other drugs?..... ☐ Yes ☐ No

If yes, are you still using them?..... ☐ Yes ☐ No

PERSONAL HISTORY

- Are you currently married or living with a significant other?.....☐ Yes ☐ No
Who lives with you at home? _____
- Are you employed?.....☐ Yes ☐ No
If yes, what kind of work do you do? _____
If no, is this by choice?___ Disability?___ Other reasons? _____
- Do you exercise more than 2 times per week?.....☐ Yes ☐ No
Do you often feel sad or depressed?..... ☐ Yes ☐ No
Do you feel there is something seriously wrong with your body?..... ☐ Yes ☐ No
Are you having money problems which limit your access to food, shelter or medical care?.....☐ Yes ☐ No
In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation?.....☐ Yes ☐ No
Do you have some form of church or spiritual support? ☐ Yes ☐ No

SEXUAL HISTORY

- Are you sexually active?☐ Yes ☐ No
With: ☐ Men ☐ Women ☐ Both
- Do you feel you are at risk for HIV/AIDS?☐ Yes ☐ No
Do you have children?☐ Yes ☐ No
How many children do you have? _____
- Do you use any form of birth control?☐ Yes ☐ No
If yes, which type / brand? _____

WOMEN ONLY

- Have you ever been pregnant? ☐ Yes ☐ No
How many times? _____
How many miscarriages? _____
How many abortions? _____
How many children do you have living? _____
- Do you have menstrual periods?☐ Yes ☐ No
If no, at what age did they stop? _____
If yes, are your periods regular? _____

OTHER COMMENTS:
