PREVENTION PLUS CLINIC

Medical History Questionnaire

Name: _____ Date of Birth:_____ Date _____

I was referred to this office by:_____

What pharmacy do you use?_____

Personal Medical History: Please check any of the following medical problems that you have had.

□Abn. Weight Loss
□Abn. Weight Gain
□Excessive Fatigue
□Insomnia
□Anemia
□Cancer or Tumor

□Glasses/Contacts
□Glaucoma
□Cataracts
□Other vision problems

□Hearing Loss
□Ear Problems
□Ringing in Ears

□Allergies
□Sinus Infections

□Dentures
□Dental Problems
□Recurrent Sores in Mouth

□Angina
□Frequent Chest Pain
□Irregular Heartbeat

□Rheumatic Fever
□High Cholesterol
□Heart Failure
□Heart Attack
□High Blood Pressure

□Breathing Problems
□Frequent Bronchitis
□Emphysema
□Pneumonia
□Asthma

□Heartburn
□Ulcer Disease
□Gallbladder Disease
□Blood in Stool
□Hepatitis
□Diarrhea, constipation
Other changes in bowl habits
□Hemorrhoids
□Abdominal Pain
□Colon Polyp

□Urinary Frequency
□Bladder Infections
□Urinary Incontinence
□Kidney Problems

□Arthritis or joint pain
□Gout
□Broken Bones

□Rashes
□Hives
□Moles

□Seizure
□TIA
□Stroke
□Numbness
□Weakness
□Memory Loss
□Headaches

□Depression
□Anxiety/Panic Attacks
□Suicide Attempt
□Physical Abuse
□Sexual Abuse
□Mental Illness

□Diabetes
□Thyroid Disease
□Sexually Transmitted Disease

□Abn. Pap smear
___#Pregnancies
___Live Births
___Miscarriages
___Abortions

Have you been exposed to or do have a close family member with…….

□HIV/AIDS
□Hepatitis
□TB

Other Medical Problems:

1._____
2._____
3._____
4._____
5._____
6._____

List ***all*** health care providers you have seen:

1._____
2._____
3._____
4._____
5._____
6._____

List ***all*** medication allergies/reaction:

1._____
2._____
3._____
4._____
5._____
6._____

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(Continue on back)

List all medications, vitamins, supplements and doses:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

List all surgeries, dates, and surgeon:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Review of Systems: Please check any of the following that you have experienced **in the last 3 weeks.**

□Changes in appetite	□Fever	□Recent weight gain (__lbs.)	□Fatigue
□Night Sweats	□Chills	□Recent weight loss (__lbs.)	
Skin/Integumentary:	□Change in a wart or mole	□Rash	□Sores that won't heal
Eyes:	□Recent changes in vision	□Double vision	□Eye Pain
Ear, Nose, and Throat (ENT):	□Loss of Hearing	□Nasal Congestion	□Trouble Swallowing
□Ringing in ears	□Seasonal Allergies	□Snoring	□Cold Symptoms
□Sore Throat			
Respiratory:	□Wheezing	□Cough	□Difficulty breathing
Cardiovascular:	□Fainting	□Calf cramps	
□Chest pain	□Heart rate is fast	□Varicose Veins	
□Irregular Heartbeat	□Swelling of extremities		
Gastrointestinal:	□Black, tarry stool	□Constipation	□Indigestion
□Bloody Stools	□Heartburn	□Vomiting	
Genitourinary:	□Blood in Urine	□Painful Intercourse	□Urinating at night
□Menstrual Irregularities	□Painful Urination		
Musculoskeletal:	□Joint Pain	□Muscle Pain	
Neurological:	□Numbness	□Headaches	
Psychiatric:	□Anxiety	□Depression	□Substance Abuse
Endocrine:	□Cold Intolerance	□Heat Intolerance	□Excessive Urination
Heme/Lymph:	□Easy Bruising	□Enlarged Lymph Nodes	

Immunization History:

Immunizations and most recent date:

□Flu Shot	Date:	□Zostavax (Shingles)	Date:
□Gardasil/HPV	Date:	□Pneumonia	Date:

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□Hepatitis A	Date:	□Tdap (Tetanus and Pertussis)	
□Hepatitis B	Date:	□Tetanus	Date:

Preventative Care:

Please list the **last year** in which you have had any of the following:

Physical Exam_____ Colonoscopy_____□Normal □Abnormal

Pap Smear_____ Dental Visit_____

Mammogram_____ Rectal/Prostate Exam_____

Bone Density_____

Social History:

Current use:	Past use:	How often per week:	How much per day:
Smoking:			
Caffeine:			
Alcohol:			
Drug Use:			

Are you sexually active? _____ Are your partners male, female, or both? _____

Do you use contraception? (Circle one) □None □Rhythm □Condoms □Pill □Vasectomy □IUD □Diaphragm □Tubal Ligation

Do you practice safe sex? □Never □Sometimes □Always

Have you **ever** had a blood transfusion? □Yes □No If yes, what year?_____

What is your marital status? □Single □Married □Separated □Divorced □Windowed □Partner

Are you currently…….. □Employed □Unemployed □Self Employed □Retired

What is your occupation? _____

Please check the following behaviors you follow:

□Wear Seatbelt □Wear helmet while riding bike or motorcycle □Smoke detector in house

□Gun in house □Fire extinguisher in house □Gun Secured by lock

□Exercise 3 or more times a week □Advance directive/living will

Other Comments_____

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_____

_____

Family History (check in the appropriate boxes to identify all illnesses/conditions in your blood relatives)

Relative	Heart Attack	High Blood Pressure	Stroke	Colon Cancer	Breast Cancer	Colon Polyp	Prostate Cancer	Other Illness	Age Living/Death
Father									
Paternal Grandfather									
Paternal Grandmother									
Mother									
Maternal Grandfather									
Maternal Grandmother									
Brother									
Sister									

Is there any family history of anxiety, depression, or other mood disorder?_____

_____

_____

_____

Is there any family history of substance abuse?_____

_____

_____

_____