

Annual Medical History Questionnaire

Name: _____ Date: _____ Date of Birth: _____

Marital Status: Single Married Divorced Widowed Reason for visit today: _____

Do you have any language or hearing needs? If so, describe _____

	Past surgeries	When	Where
1			
2			
3			
4			

	Chronic problems	Year diagNosed	Hospitalized for problem?
1			
2			
3			
4			
5			

Preferred Pharmacy and Location _____

Current medications		Current medications	
1		6	
2		7	
3		8	
4		9	
5		10	

Any kNown allergies: _____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

<u>Medical History</u>		
<u>Now</u>	<u>Past</u>	<u>Now Past</u>

<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Easy
<input type="checkbox"/>	<input type="checkbox"/>	bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Ear problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Physical
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Change in stool	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	abuse	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	STD/STI's	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

Name: _____ Date of Birth: _____

Tetanus _____

Have you ever had a flu shot? _____

Hepatitis B _____

Ever received a pneumonia shot? _____

Last Physical? _____

Ever received a shingles shot? _____

Last eye exam? _____

Last stool/hemoccult testing? _____

Last colonoScopy? _____

Last Dexa scan? _____

Last dental exam? _____

Last stress test? _____

What type of work do you do or have you done?

What is your education level? Less than high school High school diploma or equivalent Tech
education Associates degree Bachelor's degree Master's degree Doctoral

Do you exercise regularly? Yes No If Yes, describe.

Do you currently smoke? Yes No If Yes, how much

Have you ever smoked? Yes No If Yes when did you quit

Are you/have you been exposed to secondhand smoke? Yes No

Do you have an active social life? Yes No

Do you feel isolated? Yes No

Do you feel you have strong social support? Yes No

How often do you drink alcohol and how much?

Has alcohol ever caused a problem in any area of your life?

Has drug use ever caused you a problem in any area of your life?

Any history of sexually transmitted diseases or high-risk sexual behavior?

Do you live alone and if Not who else is in the home?

Do you understand enough about health resources in your community to meet your needs? Yes No

Do you have an Advanced Directive? Yes No If yes, where is it on file?

Would you like additional information on Advanced Directives? Yes No

Do you have any questions about housing/food needs? Yes No

Name: _____ Date of Birth: _____

Has any member of your **family** ever had one or more of the following diseases? If so please indicate **who** next to the problem.

Cancer/Type _____

Sickle Cell _____

Gout _____

Heart disease _____

TB _____

Suicide _____

Stroke _____

Glaucoma _____

Epilepsy _____	Diabetes _____
Asthma _____	Thyroid disorder _____
Alcoholism _____	High Cholesterol _____
Bleeding disorder _____	High blood pressure _____
Kidney disorder _____	Mental health _____

If either of your parents or any siblings are deceased, please indicate age and cause of death:

For patients that are 65 years of age and older

Did you fall in the past year? Yes No How many? _____ Did the fall(s) result in an injury? Yes No

Do you use a walking aid or has one been recommended? Yes No N/A

Details: _____

For women only

Age period began _____ Age periods stopped _____

No. of pregnancies _____ No. of miscarriages _____

No. of deliveries _____ Type of birth control used _____

Last Pap _____ Last period _____ Ever had a mammogram Yes No When? _____

Do you have pain or bleeding during intercourse Yes No Do you experience leakage of urine Yes No

For men only

History of prostate disease? Yes No Last prostate exam _____

History of impotence? Yes No

For patients 13 years of age and older

Over the past two weeks, have you felt down, depressed or hopeless? Yes No

Over the past two weeks, have you felt little interest or pleasure in doing things? Yes No

Diabetics only

Last diabetic eye exam? _____

If diabetic, what brand/model of meter: _____

Glucometer supplies from? _____

Times per day do you test?