



PATIENT MEDICAL QUESTIONNAIRE

Patient's Name: _____ Birth Date: _____ Date: _____

Allergies <input type="checkbox"/> None	Please List
Medications <input type="checkbox"/> None	Please List

Family History					
	Father	Mother		Father	Mother
Age (if living) Health (G) Bad(B)			Stroke		
			Epilepsy		
Cancer			Nervous Breakdown		
Tuberculosis			Asthma, Hives, Hay Fever		
Diabetes			Blood Disease		
Heart Trouble			Age (At Death)		
High Blood Pressure			Cause of Death		

Personal History									
Have you ever had:	Y	N		Y	N		Y	N	
Scarlet Fever			Jaundice			Broken Bones			
Diphtheria			Epilepsy			Recurrent Dislocations			
Smallpox			Migraine			<input type="checkbox"/> Concussion <input type="checkbox"/> Head Inj			
Pneumonia			Tuberculosis			Unconsciousness			
Pleurisy			Diabetes			Latex Sensitivity			
<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Heart Disease			Cancer			Chronic Fatigue Syndrome			
<input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatism			Colonoscopy/Sigmoidoscopy			Any other Disease			
<input type="checkbox"/> Bone Disease <input type="checkbox"/> Joint Disease			High Blood Pressure			Explain			
<input type="checkbox"/> Neuritis <input type="checkbox"/> Neuralgia			Nervous Breakdown						
<input type="checkbox"/> Bursitis <input type="checkbox"/> Sciatica <input type="checkbox"/> Lumbago			<input type="checkbox"/> Hay Fever <input type="checkbox"/> Asthma			Current Wt			
<input type="checkbox"/> Polio <input type="checkbox"/> Meningitis			<input type="checkbox"/> Hives <input type="checkbox"/> Eczema			Wt 1 year ago			
Venereal Disease			Frqt <input type="checkbox"/> Colds <input type="checkbox"/> Sore Throat			Max Wt/Min Wt			
Anemia			Frqt <input type="checkbox"/> Infections <input type="checkbox"/> Boils			Height			

Previous Surgery		
Procedure	Date	Surgeon



Emotions					
Are you Often ...	Y	N	Are you Often ...	Y	N
Depressed			Jumpy		
Anxious			Jittery		
Irritable			Is Concentration Difficult?		

Review of Systems					
Do you now have, or have you ever had ...	Y	N	Do you now have, or have you ever had ...	Y	N
<input type="checkbox"/> Eye Disease <input type="checkbox"/> Eye Injury <input type="checkbox"/> Impaired Sight			Extreme: <input type="checkbox"/> Tiredness <input type="checkbox"/> Weakness		
<input type="checkbox"/> Ear Disease <input type="checkbox"/> Ear Injury <input type="checkbox"/> Impaired Hearing			Kidney <input type="checkbox"/> Disease <input type="checkbox"/> Stones		
Any trouble with: <input type="checkbox"/> Nose <input type="checkbox"/> Sinuses <input type="checkbox"/> Mouth <input type="checkbox"/> Throat			Bladder Disease		
Fainting Spells			Blood in Urine		
Convulsions			<input type="checkbox"/> Protein <input type="checkbox"/> Sugar <input type="checkbox"/> Pus <input type="checkbox"/> Other in Urine		
Paralysis			Difficulty in Urination		
Dizziness			Abnormal Thirst		
Headaches: <input type="checkbox"/> Frequent <input type="checkbox"/> Severe			Prostate Trouble		
Enlarged Glands			<input type="checkbox"/> Stomach Trouble <input type="checkbox"/> Ulcer		
Thyroid: <input type="checkbox"/> Overactive <input type="checkbox"/> Underactive <input type="checkbox"/> Enlarged			Indigestion		
Enlarged Goiter			<input type="checkbox"/> Gas <input type="checkbox"/> Belching		
Skin Disease			Appendicitis		
Cough: <input type="checkbox"/> Frequent <input type="checkbox"/> Chronic			<input type="checkbox"/> Liver Disease <input type="checkbox"/> Gall Bladder Disease		
<input type="checkbox"/> Chest Pain <input type="checkbox"/> Angina Pectoris			<input type="checkbox"/> Colitis <input type="checkbox"/> Other Bowel Disease		
Spitting Up Blood			<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal Bleeding		
Night Sweats			<input type="checkbox"/> Black Tarry Stools		
Shortness of Breath <input type="checkbox"/> Exertion <input type="checkbox"/> At Night			<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea		
<input type="checkbox"/> Palpitation <input type="checkbox"/> Fluttering Heart			<input type="checkbox"/> Parasites <input type="checkbox"/> Worms		
Swelling of <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Ankles			<input type="checkbox"/> Any change in appetite <input type="checkbox"/> Eating Habits		
Varicose Veins			<input type="checkbox"/> Any change in bowel movements		

Social History					
Do you ...	Y	N	Do you use		
Exercise Adequately?			Alcoholic beverages other than socially		
Have you ever been treated for alcoholism			Tobacco		
Have you ever been treated for drug abuse					