MEDICAL HISTORY QUESTIONNAIRE (NEW PATIENT/UPDATE ANNUALLY)

SUBMIT

PRINT

Patient Label:

Primary Care Provider: _____ *Preferred Pharmacy/Location:*_____

CURRENT MEDICATIONS (PLEASE LIST VITAMINS OR SUPPLEMENTS. IF YOU HAVE A LIST PLEASE NOTE "SEE LIST")

For current patients, have there been any medication changes since your last visit? ☐*Yes* ☐ *No*

Medication	*Dose*	*Route (i.e. Oral, Topical, Vaginal, etc.)*	*Frequency (i.e. 1 time per day)*

MEDICAL HISTORY (CHECK ALL THAT APPLY AND PROVIDE THE DATE OF OCCURRENCE)

For current patients, has anything changed since your last visit? ☐*Yes* ☐ *No*

☐Alcohol Addiction_____
☐ Anemia _____
☐ Anxiety _____
☐ Asthma _____
☐ Blood clots _____
☐ Bipolar _____
☐ Breast Disease _____
☐ Cancer _____
Type:_____
☐ Chronic bronchitis _____
☐ Circulatory disease _____
☐ COPD _____
☐ Crohn's Disease _____
☐ Depression _____
☐ Other _____

☐ Diabetes Type I _____
☐ Diabetes Type II _____
☐ Emphysema _____
☐ Esophageal reflux _____
☐ Gallstones _____
☐ Heart Disease _____
☐ Liver Disease _____
☐ Other heart problems _____
Type _____
☐ Heart failure_____
☐ Hepatitis_____
☐ High blood pressure _____
☐ High cholesterol _____
☐ Irritable bowel syndrome _____
☐ Other _____

☐ Kidney Stones _____
☐ Kidney Disease _____
Type _____
☐ Migraines_____
☐ Osteoporosis _____
☐ PTSD _____
☐ Rheumatoid Arthritis_____
☐ Seizures/epilepsy_____
☐ Sleep apnea_____
☐ Stomach ulcer _____
☐ Stroke (CVA) _____
☐ Tuberculosis _____
☐Thyroid disease _____
Type: _____
☐ Other_____

ALLERGIES (MEDICATIONS, ENVIRONMENTAL, FOOD, ETC)

For current patients, have you encountered any new allergies since your last visit? ☐*Yes* ☐ *No*

_____	_____	_____
Allergen/Reaction	*Allergen/Reaction*	*Allergen/Reaction*
_____	_____	_____
Allergen/Reaction	*Allergen/Reaction*	*Allergen/Reaction*

*MENSTRUAL HISTORY ***PLEASE UPDATE****

Do you have menstrual cycles? ☐Yes: Date of last cycle: _____ ☐ No: Cycles stopped because of: _____

Age when started first menstrual cycle: _____ Flow: ☐Light ☐ Moderate ☐Heavy # Tampons/day_____ # of pads_____

Cycle: ☐ Every 28 days ☐Monthly ☐ every 20-25 days ☐ every 35-40 days ☐ Irregular Cycle Duration(days):_____

PMS Symptoms? ☐ None ☐Yes (type):_____ Painful Periods? ☐ None ☐Mild ☐ Moderate ☐Severe

*GYNECOLOGICAL HISTORY ***PLEASE UPDATE****

Year of last Mammogram?_____ Was it normal? ☐Yes ☐ No Where was it performed?_____

If abnormal did you have diagnostic testing? ☐ No ☐Yes Findings: _____

Year of last Pap Smear?_____ Was it normal? ☐Yes ☐ No Where was it performed?_____

Have you had treatment for an abnormal pap smear?: ☐ Colposcopy ☐LEEP ☐ Cryotherapy Date: _____

Are you sexually active? ☐ No ☐ Yes, with: ☐Men ☐Women ☐Both History of STDs? ☐ No ☐ Yes, type:_____

Current method of birth control: ☐ None ☐ Yes, type:_____ Treatment for Infertility? ☐ Yes ☐ No

*MENOPAUSAL HISTORY ***PLEASE UPDATE****

Age of onset of menopause: _____ Are you having any menopausal symptoms: ☐Yes ☐ No

Are you currently on hormone replacement therapy? ☐Yes ☐ No

OBSTETRICAL HISTORY

For current patients, have there been any changes since your last visit? ☐Yes ☐ No

Please provide the number of: Pregnancies: _____ Multiple Births: _____ Living children: _____

Year	*Weeks*	*C-Section, Vaginal, or Miscarriage*	*Hours of Labor*	*Gender*	*Weight*	*Anesthesia*	*Complications*	*Name of Baby*

FEMALE SURGICAL HISTORY (PLEASE PROVIDE DATE OF PROCEDURE)

For current patients, have there been any changes since your last visit? ☐Yes ☐ No

☐Hysterectomy_____ ☐D&C _____ ☐LEEP/Cone Biopsy_____ ☐Endometrial Ablation (Novasure) _____

☐Tubal Ligation/Removal_____ ☐Laparoscopy_____ ☐Myomectomy _____ ☐Breast Reduction _____

☐Breast Augmentation _____ ☐ Mastectomy: Right Left Bilateral _____ ☐Breast Biopsy _____

SURGICAL HISTORY (PLEASE PROVIDE DATE OF PROCEDURE)

For current patients, have there been any changes since your last visit? ☐*Yes* ☐ *No*

☐ Angioplasty _____
☐ Colostomy _____
☐ Laparoscopy _____
☐Appendectomy _____
☐ Gallbladder _____
☐ Open Reduction Internal Fixation _____
☐ Arthroscopy Knee _____
☐ Gastric Bypass _____
☐Oral Surgery/Wisdom Teeth _____
☐ Back Surgery _____
☐ Hernia Repair _____
☐ Pacemaker_____
☐ Coronary Artery Bypass _____
☐ Hip Replacement _____
☐ Small Bowel Resection _____
☐ Carpal Tunnel Release _____
☐Knee Replacement _____
☐ Thyroidectomy _____
☐ Cataract Extraction _____
☐ LASIK _____
☐ Tonsillectomy _____
☐ Colonoscopy _____
☐ Liver biopsy _____
☐ Other _____

HOSPITALIZATION HISTORY

For current patients, have there been any changes since your last visit? ☐*Yes* ☐ *No*

Date	*Reason for hospitalization*

FAMILY HISTORY

For current patients, have there been any changes since your last visit? ☐*Yes* ☐ *No*

	Alive/ Deceased/ Unknown	*Year of Birth or Age*	*Significant Family History*
Father			
Daughter(s)			
Son (s)			
Spouse			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			
Siblings			

SOCIAL HISTORY

For current patients, have there been any changes since your last visit? ☐*Yes* ☐ *No*

Do you exercise NO YES (Type/How often)?_____ Travel outside US? NO YES Where/When?:_____

Use illicit drugs? NO YES Type/How often?:_____ Drink alcohol? NO YES How much/often:_____

Use Tobacco? NO YES Type/How Often? _____ How many caffeinated drinks do you have in a day? _____

Pets? NO YES Type/How many?:_____ Legal Troubles? NO YES Type:_____

Current Occupation: _____ ☐Full Time ☐Part Time ☐ Homemaker ☐Student ☐Retired ☐Unemployed

Marital Status: ☐ Married ☐Single ☐Separated ☐Divorced ☐Widowed ☐Relationship with Male ☐Relationship with female

Spouses Name:_____ Occupation: _____

Are you on a special nutritional plan (ie Paleo, Keto, Mito, Adkins, etc)? ☐No ☐Yes Type:_____

Do you want to discuss physical, sexual or emotional abuse with your provider? ☐No ☐Yes (Please notify)

*DIAGNOSTIC/HEALTH MAINTENANCE (CHECK ALL THAT APPLY) ***PLEASE UPDATE***

☐ Annual Wellness Exam date: _____ ☐ Colonoscopy date: _____ ☐Date of Last Labs:_____

☐ DEXA (bone density) scan date: _____ ☐ Occult Blood Date:_____ ☐Flu Vaccine Year:_____

☐ Pneumonia Vaccine Date: _____ ☐ HPV Series Date:_____ ☐ Last tetanus vaccine:_____

☐ Zoster Vaccine Date: _____ ☐ MMR Series Date:_____ ☐ Hepatitis vaccine:_____

ADDITIONAL SPACE IF NEEDED

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____