Name:
Chart:
Date:

MEDICAL HISTORY QUESTIONNAIRE

Personal Physician: _____

Doctor's Phone # : _____

Patient's Age: _____ Patient's Occupation: _____ Height: _____ Weight: _____

A. Your Past Medical History: (Please complete the following regarding your current and past health.)

Yes	No	Have You Had?	Year	Comments
		Heart Disease		
		Heart Attack		
		High Blood Pressure		
		Stroke		
		Angina		
		Rheumatic Fever		
		Pneumonia		
		Tuberculosis		
		Asthma		
		Emphysema		
		Kidney Disease		
		Sugar Diabetes		
		Stomach Disorders		
		Ulcers		

Yes	No	Have You Had?	Year	Comments
		Liver Disease		
		Hepatitis		
		Anemia		
		Blood Clots		
		Thyroid Disease		
		Poor Circulation		
		Cancer		
		Arthritis		
		Lupus/Scleroderma		
		Fibromyalgia		
		Seizures		
		Nervous Disorders		
		Head Injury		
		Frequent Infections		

Have you or has anyone in your family ever had a problem with general anesthesia? ☐ Yes ☐ No

B. Your Previous Surgeries

Type of Surgery	Year	Hospital and/or Surgeon	Outcome

C. Your Current Medications:

Medication	Strength	How many times per day?	Medication	Strength	How many times per day?

D. Your Past Medications: (Any medication you have taken in the past 6 months)

E.Your Drug Allergies:

Medication	Reaction (Hives, Nausea, etc.)	Medication	Reaction (Hives, Nausea, etc.)

Please Complete Other Side

F. Social History:

Yes	No		Please explain
		Sleep Well	
		Use Alcohol	
		Use Tobacco	

Are you currently or have you in the past been treated in an alcohol or drug rehab program? ☐ Yes ☐ No

Date of last tetanus shot:

G. Family History: (Have any relatives had the following illness ?)

Yes	No	Illness	If yes, what relation?	Comments
		Diabetes		
		High Blood Pressure		
		Heart Disease		
		Kidney Disease		
		Stroke		
		Arthritis or Rheumatism		
		Goiter (Thyroid Disease)		
		Cancer		
		Tuberculosis		
		Seizures		
		Alcoholism		

H. Review of Systems (Please check the following symptoms experienced during the last six months)

Yes	No	Symptoms		Comments
		Constitutional:	Weight Loss	
			Fatigue	
			Fever	
		Psychiatric:	Memory Loss or Confusion	
			Depression	
		Integumentary:	Rash or Itching	
			Change in Skin Color	
		Hematology:	Slow to heal after cuts	
			Bleeding or Bruising Tendency	
		Cardiovascular:	Chest Pain or Angina	
			Irregular Heart Beat	
			Swelling of Feet or Ankles	
		Pulmonary:	Shortness of Breath	
			Wheezing	
		Gastrointestinal:	Heartburn or Reflux	
			Nausea or Vomiting	
		Genitourinary:	Rectal Bleeding or Blood in Stool	
			Burning or Painful Urination	
			Blood in Urine	
		Musculoskeletal:	Joint Stiffness or Swelling	
			Weakness of Muscles or Joints	
			Muscle Pain or Cramps	
		Neurological:	Convulsions or Seizures	
			Numbness or Tingling	
			Frequent Headaches	
		Endocrine:	Excessive Thirst or Urination	
			Heat or Cold Intolerance	

I. Your Signature: (or signature of parent or guardian)

X _____