

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____ Age: _____ Today's Date: _____

Reason for today's visit:

MEDICAL ILLNESSES:

____ None ____ Diabetes ____ High Blood Pressure
____ Stroke ____ Heart Attack ____ Heartburn
____ Asthma ____ Allergies ____ Thyroid
____ Migraines ____ Depression ____ Other psychiatric

____ OTHER _____

SURGERIES:

____ appendix ____ tonsils ____ adenoids ____ hysterectomy
____ hernia ____ ear tubes ____ tubal ligation ____ C-section ____ knee

OTHER _____

MEDICATIONS / PRESCRIPTIONS:

____ None ____ Vitamins ____ Supplements ____ Herbs

1. _____ for _____
2. _____ for _____
3. _____ for _____
4. _____ for _____
5. _____ for _____

ALLERGIES:

____ None ____ Penicillin ____ Sulfa Other: _____

FAMILY HISTORY: List any medical problems

1. Mom: _____
2. Dad: _____
3. Maternal Grandmother: _____
4. Maternal Grandfather: _____
5. Paternal Grandmother: _____
6. Paternal Grandfather: _____
7. Siblings: _____

SOCIAL HISTORY:

Marital Status: ____ single ____ married ____ divorced ____ widowed ____ other: _____

Children: _____ Siblings: _____ Pets: _____

Tobacco: _____ Alcohol: _____ Drugs: _____