MEDICAL HISTORY QUESTIONNAIRE

Patient's name _____ Date _____

I. This is a confidential questionnaire. Please answer each question as completely as possible. This information will help your physicians and nurses provide you with the best possible care.

II. Past History

1. Are you taking or recently have been taking any medicine?
(Include aspirin, sleeping pills, birth control pills, etc.)
If "yes" please list below: Yes No

Medication	Amount per day	When Started

2. Do you have an allergy to or have you had a serious reaction to any medicine, anesthetic, or compound used internally or on the skin? If "yes", please list below: Yes No

Medication	Type of reaction

3. Have you ever had surgery or required hospitalization for a medical problem. If "yes" list below:
Yes No

Year	Reason	Hospital

4. Please list below all medical problems such as kidney disease, diabetes, hepatitis, heart trouble, cancer, etc.

Year	Medical Problem

Past History (cont'd)

5. a. Do you smoke or have you been a smoker? Yes No
If "yes", describe type, amount and duration
of smoking habit _____
_____

b. Do you drink? If "yes", please indicate Yes No
amount and duration. _____
_____

c. Has drinking ever been a problem for you? Yes No

d. Have you ever been addicted or habituated to
drugs or alcohol? Yes No

e. Are you on a special diet or do you restrict
your diet in any way? If "yes", please Yes No
explain _____
_____
_____

III. REVIEW OF SYSTEMS

Have you had any of the following in a serious or chronic way?
If "yes", circle the number of the items.

A. EYE PROBLEMS? — Yes ☐ No ☐

1. Double vision?
2. Blurring of vision?
3. Puffy eyelids?
4. Injury of eyes?
5. Infection of eyes?
5. Painful eyes?
7. Colored rings around lights
8. Temporary loss of vision?
9. Others?_____

B. EAR TROUBLE? — Yes ☐ No ☐

1. Pain in the ears?
2. Discharge from ears?
3. Ringing in the ears?
4. Mastoid trouble?
5. Others?_____

C. NOSE, THROAT, OR MOUTH DISORDERS? — Yes ☐ No ☐

1. Nasal stuffiness or discharge without a cold"?
2. Frequent sneezing spells?
3. Prolonged or re-curring sinus pains?
4. Frequent or severe nose bleeds?
5. Prolonged or re-curring sore throats?
6. Recurring hoarseness?
7. Sore mouth or tongue?
8. Severe teeth or gum problems?
9. Others?_____

D. BREAST PROBLEMS? — Yes ☐ No ☐

1. Lumps in breasts?
2. Soreness of breasts?
3. Discharge from breasts?
4. Change in size of breasts?
5. Others?_____

E. HEART, LUNGS, OR CIRCULATORY PROBLEMS? — Yes ☐ No ☐

1. Heart murmur?
2. High blood pressure?
3. Rapid or irregular beating of heart?
4. Shortness of breath with little effort?
5. Shortness of breath when lying down flat?
6. Pains or tightness in your chest?
7. Swelling of your feet or ankles?
8. Wheezing or noisy breathing?
9. Recurrent or per-sistent cough?
10. Coughing up blood?
11. Chest pains with a deep breath?
12. Soaking sweats at night time?
13. Cramps in legs when walking?
14. Varicose vein trouble?
15. Phlebitis? (Inflamation of veins)
16. Others?_____

F. DIGESTIVE, STOMACH OR INTESTINAL DIFFICULTIES? — Yes ☐ No ☐

1. Difficult or painful swallowing?
2. Poor appetite?
3. Nausea or vomiting?
4. Vomited blood?
5. Heartburn or dis-comfort in "pit" of your stomach?
6. Pains or soreness in abdomen?
7. Unusual bloating or swelling of abdomen?
8. Unusual burping or passing of gas?
9. Loose bowel movements for more than a day?
10. Gray bowel movements?
11. Black or bloody movements?
12. Unusual constipation?
13. Painful bowel movements?
14. Bleeding from rectum?
15. Soreness or pain in rectal area?
16. Jaundice (yellowness of skin or eyes)?
17. Others?_____

G. URINARY OR GENITAL PROBLEMS? . . . . . Yes ☐ No ☐

1. Pain or burning with urination?
2. Frequent urination at night?
3. Urinating more than 5-6 times a day?
4. Trouble holding urine? (wetting)
5. Difficulty starting urination?
6. Brown or bloody urine?
7. Pus or albumin in the urine?
8. Kidney stones or colic?
9. Sores on genitals?
10. (MEN)
    a) Weak or slow urine stream?
    b) Prostate trouble?
    c) Discharge from penis?
    d) Pain or swelling of testes?
    e) Difficulty with erection or intercourse?
11. (Women)
    a) Excessive vaginal discharge or soreness?
    b) Pain or difficulty with intercourse?
    c) Have your menstrual periods stopped?
    d) Heavy bleeding with periods?
    e) Bleeding between periods?
    f) Irregular periods or abnormal periods?

When was your last period?_____ Number of pregnancies?_____
Number of children born alive?_____ Number of ceasarian sections?_____
Number of stillbirths, miscarriages or abortions?_____

H. BONE OR JOINT PROBLEMS? . . . . . Yes ☐ No ☐

1. Painful joints or back?
2. Swollen joints?
3. Stiffness of joints?
4. Others?_____

I. MUSCULAR, BRAIN OR NERVE DISORDERS? . . . . . Yes ☐ No ☐

1. Serious head injury?
2. Frequent or severe headaches?
3. Fainting spells?
4. Fits or epilepsy?
5. Dizziness or trouble with balance?
6. Twitching, shaking, or trembling?
7. Unusual loss of co-ordination or strength?
8. Tingling or numbness in any part of your body?
9. Loss of sense of smell, taste, etc.?
10. Loss of sense of touch or pain?

J. BLOOD DISORDERS OR BLEEDING PROBLEMS? . . . . . Yes ☐ No ☐

1. Anemia or abnormal blood count?
2. Tendency to bruise easily?
3. Trouble stopping bleeding from even a small cut?
4. Enlargement of lymph glands?
5. Other?_____

K. THYROID OR GLANDULAR PROBLEMS? . . . . . Yes ☐ No ☐

1. Goiter (enlarged thyroid gland?)
2. Unusual sensitivity to heat or cold?
3. Bulging or prominence of eyes?
4. Unusual thirst or urinating large amounts?
5. Change in appetite?
6. Tired or exhausted most of the time?
7. Frequent boils or skin infections?
8. Unusual skin rashes or blotches?
9. Unusual grown or loss of hair?

L. UNUSUAL STRESS OR EMOTIONAL PROBLEMS? . . . . . Yes ☐ No ☐

1. Unhappiness with work or family?
2. Difficulty relaxing?
3. Unusual nervousness?
4. Frequent or disturbing worries?
5. Difficulty making decisions?
6. Annoyance with minor matters?
7. Trouble concentrating?
8. Trouble with memory?
9. Desire to avoid most people?
10. Trouble with loneliness or hopelessness?
11. Frequent crying?
12. Thoughts of suicide?
13. Trouble controlling temper?
14. Unsatisfactory social relationships?

IV. FAMILY HISTORY

(Check appropriate box - "X")

Relative	Living	Well	Sick	Dead	Age now or at time of death	Cause of illness or death
1. Father						
2. Mother						
3. Brothers & Sisters						
4. Spouse						
5. Children						

Has any blood relative:

	Yes	No	If yes, indicate who (father, sister, etc.)
had tuberculosis?			
had cancer or tumor?			
had heart trouble?			
had chronic lung disease?			
had unusual bleeding problem?			
had diabetes?			
had thyroid disease (goiter, etc.)?			
had gout?			
had epilepsy?			
had mental illness or nervous breakdown?			
been an alcoholic?			

Date: _____

_____

Signature of person answering questionnaire