Patient Medical History Questionnaire

Name _____DOB _____Age_____ Date_____

Occupation _____Family Doctor _____

Chief Complaint (primary reason for this visit) _____

History of Present Illness_____

_____

Medications (list name, strength, frequency) Do you take Aspirin? _____ How often? _____

_____

_____

Allergies (Include if allergic to medications, anesthetics or tape)

_____

Previous Operations	**Type**	**Date**	**Diagnosis**	**Surgeon/Hospital**
_____		_____	_____	_____
_____		_____	_____	_____
_____		_____	_____	_____

Illnesses/Hospitalizations (include reason and dates): Hypertension? _____ Diabetes? _____

_____

_____

Habits Height: _____ Weight: _____

Do you currently smoke? _____ In the past? _____ How much? _____ How long?_____

Do you drink alcohol? _____ In the past? _____ How much? _____How long?_____

Other drug use? _____ How often? _____

Family History Have any blood relatives had (or died from) any of the following? (indicate relationship)

Cancer (if yes, fill out familiy history form) _____ AIDS _____ Hepatitis _____

Heart Disease _____ Ulcer Disease _____ Bleeding Disorder _____

Other? _____