MEDICAL HISTORY QUESTIONNAIRE

Name:_____Birthdate:_____/_____/_____Date:_____/_____/_____
Occupation:_____ Marital Status: Single ☐ Married ☐ Divorced ☐
Primary Care Physician:_____
Please list current medications: *(If unsure of names please list what they are for)*

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list: ↓↓ Any major surgeries/hospitalizations ☐ YES ☐ NO

_____ _____ _____

_____ _____ _____

Family History: Does anyone in your **family** have:	**Social History:** Do you/are you:
☐ High blood pressure ☐ Glaucoma	☐ Smoke ☐ Currently pregnant
☐ Diabetes ☐ Macular degeneration	☐ Had blood transfusion ☐ Use recreational drugs
	☐ Drink Alcohol

Review of Systems *Please check any that apply to you.* If none apply, please check HERE ☺ ☐

Do you have any NON-MEDICATION allergies? ☐ YES ☐ NO *If yes, please list*

_____ _____ _____

Cardiovascular	Yes	No
Angina	☐	☐
Cardiovascular Disease	☐	☐
Hypertension	☐	☐
Stroke	☐	☐
Weight loss/gain	☐	☐
Headaches	☐	☐

Endocrine	Yes	No
Cholesterol Elevated	☐	☐
Thyroid Disorder	☐	☐
Diabetic	☐	☐

*If yes, how long?*_____
*Last A1C*_____
*Last Glucose Reading*_____
Is Sugar: ☐ Controlled ☐ Fluctuating

Gastro Intestinal	Yes	No
Acid Reflux	☐	☐
Gastro System Disorder	☐	☐

Gentourinany	Yes	No
Prostate Disorder	☐	☐
Syphillis	☐	☐

Hematologic/Lymphatic	Yes	No
Anemia	☐	☐
Breast Carcinoma	☐	☐
Coagulation Disorder	☐	☐
Sickle Cell	☐	☐

Immunologic	Yes	No
Herpes Simplex	☐	☐
Herpes Zoster	☐	☐
HIV Positive	☐	☐
Tuberculosis	☐	☐

Integumentary (Skin)	Yes	No
Albinism	☐	☐
Breast Carcinoma	☐	☐
Coagulation Disorder	☐	☐

Musculoskeletal	Yes	No
Arthritis	☐	☐
Downs Syndrome	☐	☐
Myasthenia Gravis	☐	☐
Osteoporosis	☐	☐

Neurological	Yes	No
Bells Palsy	☐	☐
Brain Tumor/Damage	☐	☐
Cerebral Palsy	☐	☐
Epilepsy	☐	☐
Headaches	☐	☐
MS	☐	☐
Vertigo	☐	☐

Psychiatric	Yes	No
Attention Deficit Disorder *(ADD/ADHD)*	☐	☐
Bipolar	☐	☐
Dementia	☐	☐
Depression	☐	☐
Psychiatric Disorder	☐	☐
Schizophrenia	☐	☐

Respiratory		
Asthma	☐	☐
Cancer//Lung	☐	☐
COPD	☐	☐
Sarcoidosis	☐	☐

Patient's Signature	**Date**	**Doctor's Signature**