

PATIENT MEDICAL QUESTIONNAIRE
MICHAEL A. WALDMAN, M.D., FACP

NAME: _____ DATE: _____ D.O.B. _____ M/F

Please list any childhood diseases: _____

PAST MEDICAL HISTORY Please indicate if you have had any of the following:

<input type="checkbox"/> hypertension	<input type="checkbox"/> asthma	<input type="checkbox"/> cancer
<input type="checkbox"/> diabetes	<input type="checkbox"/> depression	if yes, location:
<input type="checkbox"/> arthritis	<input type="checkbox"/> diverticulosis	<input type="checkbox"/> breast
<input type="checkbox"/> heart attack	<input type="checkbox"/> emphysema	<input type="checkbox"/> lung
<input type="checkbox"/> abnormal heart beat	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> kidney
<input type="checkbox"/> rheumatic heart disease	<input type="checkbox"/> kidney disease	<input type="checkbox"/> skin
<input type="checkbox"/> angina	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> other _____
other _____		

PAST SURGICAL HISTORY Please indicate past surgeries, and if known, the date(month/year)

tonsils and adenoids
 appendectomy
 other _____

PLEASE LIST CURRENT MEDICATIONS AND DOSES

Medication Name Dose amount Frequency

DO YOU HAVE ANY ALLERGIES? IF YES, TO WHAT? Please list the reaction you had.

FAMILY HISTORY LIVING? AGE? CAUSE OF DEATH?

FATHER:	_____	_____	_____
MOTHER:	_____	_____	_____
SISTER:	_____	_____	_____
BROTHERS:	_____	_____	_____

PLEASE CIRCLE, IF YOU HAVE A HISTORY OF *COLON, PROSTATE, OVARY OR BREAST* CANCER IN YOUR MOTHER, FATHER OR SIBLINGS. IF SO, HOW OLD WERE THEY WHEN THEY WERE DIAGNOSED

SOCIAL HISTORY

DO YOU SMOKE? _____ IF YES, FOR HOW LONG? _____
DO YOU DRINK ALCOHOL? _____ IF YES, HOW MUCH/LONG? _____
DO YOU USE ILLEGAL DRUGS? _____

MARITAL STATUS:

__SINGLE __MARRIED __WIDOWED __DIVORCED __SEPARATED

GYN HISTORY

Date of last menstrual period _____
Date of last pap smear _____
Date of last mammogram _____

VACCINATIONS Date of last Tetanus _____

Date of Pneumovax _____