

# Patient Medical Questionnaire

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**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Past Medical History**-Please indicate if you have ever had any of the following:

Abnormal heart beat _____	Diverticulosis _____	Stroke _____
Angina _____	Emphysema _____	Tuberculosis _____
Arthritis(Where) _____	High Cholesterol _____	Breast Cancer _____
Asthma _____	Hypertension _____	Colon Cancer _____
Chickenpox _____	Heart Attack _____	Ovarian Cancer _____
Depression _____	Kidney Disease _____	Prostate Cancer _____
Diabetes _____	Rheumatic Heart Disease _____	Other Cancer _____
Other _____		

**Past Surgical History**- Please indicate past surgeries and date:

\_\_\_\_\_  
\_\_\_\_\_

**Current Medications and Dose**-Please list:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:**

\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Marital Status \_\_\_\_\_ Children \_\_\_\_\_  
Occupation \_\_\_\_\_

**Habits:**

Tobacco: Smoke \_\_\_\_\_ Current \_\_\_\_\_ Former \_\_\_\_\_ Quit Date \_\_\_\_\_ #per day \_\_\_\_\_ # of years \_\_\_\_\_  
Alcohol: \_\_\_\_\_ Drinks per day: \_\_\_\_\_ Caffeine: \_\_\_\_\_ Illegal Drug Use: \_\_\_\_\_ Exercise \_\_\_\_\_

**GYN History:**

Age menopause began \_\_\_\_\_ Number of pregnancies \_\_\_\_\_ Last Menstrual period \_\_\_\_\_  
Date of last papsmear \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_  
Last mammogram \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

**Vaccinations:**

Tetanus: \_\_\_\_\_ Varicella: \_\_\_\_\_ Flu vaccine: \_\_\_\_\_ Pneumovax \_\_\_\_\_

**Family History**- Please indicate if any of your family members have had the following:

Diabetes _____	Breast Cancer _____
Heart Disease _____	Colon Cancer _____
Hypertension _____	Ovarian Cancer _____
Stroke _____	Prostate Cancer _____
Tuberculosis _____	Other Cancer _____
Other _____	

**Screening:**

Date of last Colonoscopy: \_\_\_\_\_ Reason for procedure: \_\_\_\_\_  
Name of physician: \_\_\_\_\_