Medical History Questionnaire

Name | **Age**

Reason for Your Visit

Do You Have Any Allergies?

Medicines:

Environmental or Food:

Past Medical History

- Please check the boxes to indicate whether you have any of the following illnesses; please explain the "yes" answers:

	Yes	No	
High Blood Pressure	☐	☐	
Heart Disease	☐	☐	
Diabetes	☐	☐	
Respiratory Problems	☐	☐	
Stomach or Intestinal Problems	☐	☐	
Kidney Disorders	☐	☐	
Thyroid Problems	☐	☐	
Neurological Problems	☐	☐	
Tumors or Cancer	☐	☐	
Other Medical Problems	☐	☐	

- Please list all previous operations including dates:

Medications

Please list all medications:

Social History

	Yes	No	
Have you ever been a smoker?	☐	☐	How many cigarettes per day? ____ When did you quit? ____
Do you drink alcohol?	☐	☐	
Any history of drug use?	☐	☐	
What is your occupation?			
What is your marital status?			

Family History

Please check the boxes to indicate whether your relatives have any of the following illnesses:

	Yes	No	
Hearing Problems	☐	☐	
Allergies/Hay Fever	☐	☐	
Thyroid Problems	☐	☐	
Diabetes	☐	☐	
Respiratory Problems	☐	☐	
Heart Problems	☐	☐	
Cancer	☐	☐	
Bleeding Disorders	☐	☐	
Anesthesia Complications	☐	☐	
Other Medical Problems	☐	☐	

Medical History Questionnaire

Review of Systems

Please check the boxes to indicate whether you have any of the following symptoms:

		Yes	No		Yes	No
General	Weight Loss or Gain	☐	☐	Night Sweats	☐	☐
	Fatigue	☐	☐	Poor Appetite	☐	☐
Eyes	Eye Pain	☐	☐	Double Vision	☐	☐
	Watery or Itchy eyes	☐	☐	Sudden Vision change	☐	☐
ENT	Hearing Loss	☐	☐	Ear Noises	☐	☐
	Dizziness	☐	☐	Ear Pain	☐	☐
	Nasal Congestion	☐	☐	Sinus Pressure or Pain	☐	☐
	Problems with the Sense of Smell	☐	☐	Nosebleed	☐	☐
	Snoring	☐	☐	Daytime Sleepiness	☐	☐
	Hoarseness	☐	☐	Throat Clearing	☐	☐
	Difficulty Swallowing	☐	☐	Throat Pain	☐	☐
Allergy	Sneezing	☐	☐	Post Nasal Drip	☐	☐
	Previous Allergy Testing	☐	☐	Lip or Tongue Swelling	☐	☐
	If yes, what were the results? _____					
Respiratory	Cough	☐	☐	Coughing Blood	☐	☐
	Shortness of Breath	☐	☐	Wheezing	☐	☐
Cardiac	Chest Pain	☐	☐	Palpitation	☐	☐
Gastor-Intestinal	Nausea or Vomiting	☐	☐	Heartburn	☐	☐
	Regurgitation	☐	☐	Abdominal Pain	☐	☐
Genito-Urinary	Frequent Urination	☐	☐	Pain with Urination	☐	☐
	Blood in Urine	☐	☐	Incontinence	☐	☐
Musculo-skeletal	Joint Ache	☐	☐	Muscle Pain	☐	☐
	Bone Pain	☐	☐	Muscle Spasm	☐	☐
	Hammer Toes	☐	☐	Foot Ulcers	☐	☐
	Bunions	☐	☐	Foot pain	☐	☐
Heme-Lymphatics	Swollen Glands	☐	☐	Frequent Infections	☐	☐
	Bleeding Problems	☐	☐	Easy Bruising	☐	☐
Endocrine	Feeling warm at all times	☐	☐	Feeling cold at all times	☐	☐
Skin	Rash	☐	☐	Hives	☐	☐
	Itching	☐	☐	Skin or Hair Changes	☐	☐
Neuro-Psych.	Depression	☐	☐	Mood Swings	☐	☐
	Headache	☐	☐	Seizures	☐	☐
	Numbness	☐	☐	Weakness	☐	☐

Patient Signature _____ **Date** _____