MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Appointment Date: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Primary Care Doctor: _____

Pharmacy (Name/Location/Phone): _____

REASON FOR VISIT:
- ☐ **Hospital follow up**
- ☐ **Surgery clearance**
- ☐ **Heart issue** _____
- ☐ **Other** _____

DO YOU HAVE A LIVING WILL OR A MEDICAL POWER OF ATTORNEY? ☐ **YES** ☐ **NO**
HAVE YOU HAD THIS SEASON'S FLU IMMUNIZATION? ☐ **YES** ☐ **NO** **DATE:** _____
HAVE YOU HAD YOUR PNEUMONIA IMMUNIZATION? ☐ **YES** ☐ **NO** **DATE:** _____

ALLERGIES:

Have you had a reaction to X-Ray contrast dye?	☐ Yes ☐ No
Are you allergic to iodine or shellfish?	☐ Yes ☐ No
Are you allergic to any adhesives?	☐ Yes ☐ No
Are you allergic to any medications?	☐ Yes ☐ No If yes, _____

PAST MEDICAL HISTORY (Please indicate if you have been diagnosed with any of the following **by a physician**.)

- ☐ Arthritis
- ☐ A-Fib _____
- ☐ Anemia
- ☐ Angina
- ☐ Arrhythmia _____
- ☐ Asthma
- ☐ Syncope (passing out)
- ☐ Thyroid Disorder ◯ Low ◯ High
- ☐ Blood Clots in Veins or Lungs
- ☐ HIV
- ☐ AIDS
- ☐ Aneurysm
- ☐ Carotid Disease
- ☐ Heart Failure
- ☐ Clotting Disorder
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Heart Murmur
- ☐ Cancer _____
- ☐ Cardiomyopathy
- ☐ COPD
- ☐ Liver Problems
- ☐ Anxiety
- ☐ _____
- ☐ Kidney disease
- ☐ Heart Attack
- ☐ Peripheral Arterial Disease (PAD)
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TIA
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Emphysema
- ☐ Hepatitis **A B or C**
- ☐ Depression
- ☐ _____

PAST SURGICAL HISTORY

☐ AAA Repair	☐ Carotid Stenting	☐ Peripheral Stenting
☐ Cardiac Ablation	☐ Coronary Stenting	☐ Valve Repair/Replacement
☐ ASD Repair	☐ ICD	☐ VSD Repair
☐ Coronary Bypass	☐ Pacemaker	☐ Cardioversion
☐ Gall Bladder(Removed?) **Y N**	☐ Hysterectomy	☐ C-Section
☐ Tonsils	☐ Adenoids	☐ Fracture_____
☐ Vasectomy	☐ Carpal Tunnel Release	☐ Cataract ☐ Left ☐ Right
☐ Hip Replacement ☐ Left ☐ Right	☐ Knee Replacement ☐ Left ☐ Right	☐ Knee Surgery_____
☐ Appendectomy	☐ _____	☐ _____

FAMILY HISTORY

☐ Adopted
☐ Family History Unknown

Relationship	Alive or Deceased?	A-Fib	Coronary Artery Disease	Clotting Disorder	Diabetes	Heart Attack	Heart Disease	Heart Failure	High Cholesterol	High Blood Pressure	Stroke	Other
Mother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

(If writing in a grandparent or aunt/uncle, please specify maternal or paternal.)

YOUR SOCIAL HISTORY AND HABITS

Alcohol use, including beer: ☐ Yes ☐ No If yes, how many per day? _____

DRUG USE: Have you ever used intravenous drugs or cocaine? ☐ Yes ☐ No

Have you ever used other illegal drugs or been addicted to prescription pain medications? ☐ Yes ☐ No

If yes, explain _____

TOBACCO USE: ☐ Never Smoker

☐ Current Smoker

If current, _____ packs per day for _____ years

☐ Former Smoker

If former, quit date? _____

Do you have second-hand smoke exposure? ☐ Yes ☐ No

Currently use smokeless tobacco: ☐ CHEW ☐ SNUFF ☐ E-CIG

If previous tobacco user, _____ years. Quit date? _____

DO YOU EXERCISE REGULARLY? ☐ Yes ☐ No

CAFFEINE USE: How many caffeinated beverages do you drink per day (Coffee, soft drinks, tea)? _____

A REVIEW OF YOUR CLINICAL SYSTEMS (Please check all that apply)

What symptoms are you feeling today?

CONSTITUTION: Has there been a change in your ability to function as you normally do? ☐ Yes ☐ No
☐ Malaise/Fatigue ☐ Weight Gain ☐ Weight Loss

EYES: ☐ Vision Loss - Left ☐ Vision Loss - Right ☐ Visual Halos

RESPIRATORY: ☐ Cough ☐ Shortness of Breath ☐ Sleep Disturbance Due to Breathing ☐ Snoring ☐ Wheezing

SKIN: ☐ Skin Ulcers ☐ Poor Wound Healing

HENT: ☐ Headaches

CARDIACVASCULAR: ☐ Chest Pain ☐ Claudication(Calf pain with walking) ☐ Leg Swelling
☐ Dyspnea on Exertion(Shortness of breathing with exertion)
☐ Orthopnea(Shortness of breath when lying down)
☐ PND (Attacks of shortness of breath that wake you)
☐ Palpitations(Irregular heartbeat)

ENDOCRINE: ☐ Intolerance of Cold ☐ Intolerance of Heat ☐ Polyuria(Frequent urination)

HEME/LYMPH: ☐ Bleeding ☐ Easy Bruising/Bleeding ☐ Clotting Tendency

MUSCULOSKELETAL: ☐ Arthritis ☐ Falls ☐ Joint Pain ☐ Muscle Cramps ☐ Muscle Weakness

GASTROINTESTINAL: ☐ Abdominal Bleeding ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn
☐ Melena(Dark tarry stool) ☐ Nausea ☐ Vomiting

GENITOURINARY: ☐ Hematuria(Blood in urine) ☐ Nocturia(Frequent nighttime urination)

NEUROLOGICAL: ☐ Daytime Sleepiness ☐ Dizziness ☐ Seizures ☐ Blackouts ☐ Vertigo

PSYCHIATRIC: ☐ Altered Mental Status ☐ Depression ☐ Memory Loss ☐ Anxiety or Nervousness

OTHER SYMPTOMS: _____

PATIENTS 65 YEARS OF AGE AND OLDER:

Have you fallen within the last three months? ☐ YES ☐ NO