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** _____

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: ◯ Yes ◯ No

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 add any patient details below)

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

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)

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: _____