MEDICAL HISTORY QUESTIONAIRE

Do you have or have you ever had any of the following conditions ?

	Y	N
General		
Weakness		
Persistent fever		
Unexplained weight change		
Swollen ankles		
Swollen joints		
Rash or hives		
Altered skin pigmentation		
Sensory System		
Visual changes		
Glaucoma		
Ringing in ears		
Loss of hearing		
Sinus problems		
Frequent nose bleeds		
Sinus surgery		
Throat		
Soreness or hoarseness		
Tonsilectomy		
Nervous System		
Frequent headaches		
Numbness or tingling		
Fainting or dizziness		
Epilepsy / Seizures		
Stroke		
Bones / Joints		
Painful joints (including jaw)		
Arthritis		
Prosthetic joints		

	Y	N
Endocrine System		
Diabetes		
IDDM (Type I)		
NIDDM (Type II)		
Thyroid disease (goiter)		
Respiratory System		
Hayfever		
Persistent cough		
Difficulty breathing		
Asthma		
Tuberculosis / PPD +		
Emphysema		
COPD		
Heart Diseases		
Congenital heart disease		
Mitral valve prolapse		
Rheumatic fever		
Heart murmur		
Hypertension		
(High blood pressure)		
Congestive heart failure		
Angina (chest pain)		
MI (heart attack)		
Heart surgery (by-pass, etc)		
Prosthetic heart valves		
Pacemaker		
Do you use tobacco ?		
Do you drink alcohol ?		

	Y	N
Blood / Immune Diseases		
Sickle cell disease		
G6PD disease		
Bruise or bleed easily		
Hemophilia		
Anemia		
Blood transfusions		
HIV+ / AIDS		
GI System		
Ulcers (stomach)		
Jaundice		
Hepatitis (A B C other)		
Cirrhosis *circle one*		
Kidney problems / stones		
Incr frequency of urination		
Urinary tract infection		
Sexually transmitted diseases		
Other		
Tumors / Growths		
Cancer		
type:		
Chemotherapy		
Radiation therapy		
Steroid therapy		
Recreational drug use		
Psychiatric treatment		
How much ?		
How much ?		

Do you have any disease, condition or problem not listed above ? **Yes** **No**

If yes, please explain :

Physician / Hospitalizations

Are you currently under the care of a physician ? **Yes** **No**

If yes, for what condition: _____

Physician(s)' name(s): _____ Phone # : ( ) -_____

_____ ( ) -_____

Have you ever been hospitalized ? **Yes** **No**

If yes,please explain : _____

Medications

Are you allergic to any medications ? **Yes** **No**

If yes, please list : _____

Are you currently taking any medications ? **Yes** **No**

If yes, please complete the "List of Current Medications" form

Women

Are you on birth control medications ? **Yes** **No**

Are you, or might you be pregnant ? **Yes** **No** Due date : _____

Comments | Reviewer's Sig | Date

_____ Patient Signature / Date

_____ Doctor's Signature / Date

Patient Name :