



MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____

Chief Complaint: _____

FAMILY HISTORY: Give age if living or age and cause of death.

Father _____

Mother _____

Siblings _____

Children _____

Is there an immediate family history (someone related by blood) of any of the following:

	Yes	No		Yes	No
Heart Trouble			Stroke		
Bleeding Tendency			Keloid Formation		
Diabetes			Cancer		
High Blood Pressure			Other		

ALLERGIES AND SENSITIVITIES: Indicate which, if any are present:

	Yes	No		Yes	No
Penicillin			Aspirin		
Other Antibiotics			Tetanus Toxoid		
Xylocaine			Adhesive Tape		
Codeine			Other		

MEDICATIONS: List all medications you currently take:

Dosage

Frequency

Cortisone, ACTH, other steroids	_____	_____
Sedatives, Sleeping Pills, Tranquilizers	_____	_____
Blood Pressure Regulators	_____	_____
Digitalis, Nitroglycerine, Cardiac Drugs	_____	_____
Thyroid	_____	_____
Aspirin, Coumadin, Heparin	_____	_____
Birth Control Pills/Hormones	_____	_____
Appetite Suppressants- including Phen-Fen	_____	_____
Herbal/Homeopathic	_____	_____
Other _____	_____	_____

SOCIAL HISTORY (circle one)

Tobacco: None 1pack/day or less 2 packs/day More
 Alcohol: None Socially Daily
 Drugs: None Marijuana Cocaine Other



SURGICAL HISTORY: List all prior surgeries, as well as cosmetic (including chemical peels).

Type: _____ Date: _____ Surgeon: _____
 Type: _____ Date: _____ Surgeon: _____
 Type : _____ Date: _____ Surgeon: _____

Did you experience any problems or complications during or following above procedures?

No _____ Yes _____ Please explain _____

PAST MEDICAL HISTORY: List any prior hospitalizations below (e.g. accidents, surgeries, etc.).

Purpose: _____ Date: _____ Physician: _____
 Purpose: _____ Date: _____ Physician: _____
 Purpose: _____ Date: _____ Physician: _____

Have you recently been under the care of a physician for any reason? Yes _____ No _____

If yes, please explain: _____

Name, Address & Telephone Number of Physician: _____

REVIEW OF SYSTEMS: Check if any apply:

	Yes	No		Yes	No
Skin Disease	___	___	High/Low Blood Pressure	___	___
Eye, Ear, Nose Throat	___	___	Rheumatic Fever	___	___
Thyroid	___	___	Anemia, Bleeding Problems	___	___
Palpitations	___	___	Arthritis	___	___
Diabetes	___	___	Liver	___	___
Shortness of Breath	___	___	Psychiatric	___	___
Chronic Cough	___	___	Tuberculosis	___	___
Asthma	___	___	Hepatitis	___	___
Chest Pain/Heart Murmur	___	___	HIV	___	___

Is there any history not noted above of which the doctor should be aware? Yes _____ No _____

If yes, please explain: _____

This information is correct and true to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____