Adult (>17 year old) Medical/Family History Questionnaire

Adults 18 years and older please complete this form. Patients 0 to 17 years please complete the form on the next page.

Name_____ SS#_____ Date_____
Birth Date_____ Chief Complaint_____

DRUG ALLERGIES

_____
_____
_____
_____

CURRENT MEDS

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

	father	mother	father's parents	mother's parents	siblings	children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						

Number of: Brothers:_____ Sisters:_____

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ____Yes ____No Planning Pregnancy? ____Yes ____No

PAST MEDICAL HISTORY

- ❑ Headache_____
- ❑ Shortness of Breath_____
- ❑ Heart Palpitations_____
- ❑ Heart Murmur_____
- ❑ Chest Pain_____
- ❑ Dizziness/Fainting_____
- ❑ Peripheral Vascular Disease_
- ❑ Allergies/Hay Fever_____
- ❑ Asthma_____
- ❑ Bronchitis_____
- ❑ Pneumonia_____
- ❑ Ulcer_____
- ❑ GI Disorder_____
- ❑ Gall Bladder Disease_____
- ❑ Prostate Disease_____
- ❑ Bowel Irregularity_____
- ❑ Sexual/Menstrual Dysfunction_____
- ❑ Venereal Disease_____
- ❑ Frequent Infections_____
- ❑ Hepatitis_____
- ❑ Anemia_____
- ❑ Arthritis_____
- ❑ Nervousness_____
- ❑ Depression_____
- ❑ Gout_____
- ❑ Chronic Rashes_____
- ❑ Rheumatic Fever_____
- ❑ Mumps_____
- ❑ Measles_____
- ❑ Rubella_____
- ❑ Polio_____
- ❑ Diphtheria_____
- ❑ Tetanus_____
- ❑ Other_____

HABITS

- ❑ Smoke: Packs daily_____ How long?_____ When stopped?_____
- ❑ Exercise routine_____ Coffee: Cups daily_____ Other caffeine_____
- ❑ Alcohol: Type/Amount_____ Sleep pattern_____
- ❑ Diet: Salt intake_____ Fat intake_____
- ❑ Contact with blood or body fluid at work_____

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