Medical History Questionnaire

The information you provide is personal and confidential.

Name: ____
Date of Birth: __________________________________
Home Phone: _________________________________

Are you currently under the care of any Medical Doctors? ____ Yes ___ No
If yes please list:

Name	Address	Phone No.	Reason

Are you on any medications? ___ Yes ____ No
If yes please list:

Name of Medication (s):	Dosage	Frequency	Diagnosis

Have you ever contemplated or attempted suicide? ____ Yes ____ No
If yes, give details

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Psychiatric: *Have you ever had or do you now have any of the following illnesses or problems?*	**No**	**Yes Past**	**Yes Current**
Depression			
If yes, when and for how long? Who gave the diagnosis?			
Drug Abuse\Dependency			
If yes, when and for how long? Who gave the diagnosis?			
Alcohol Abuse\Dependence			
If yes, when and for how long? Who gave the diagnosis?			
Anxiety Attacks			
If yes, when and for how long? Who gave the diagnosis?			
Obsessive/Compulsive Disorder			
If yes, when and for how long? Who gave the diagnosis?			
Borderline Personality			
If yes, when and for how long? Who gave the diagnosis?			

Psychiatric: Have you ever had or do you now have any of the following illnesses or problems?	**No**	**Yes Past**	**Yes Current**
Schizophrenia			
If yes, when and for how long? Who gave the diagnosis?			
Anorexia Nervosa			
If yes, when and for how long? Who gave the diagnosis?			
Bulimia Nervosa			
If yes, when and for how long? Who gave the diagnosis?			
Bipolar Disorder			
If yes, when and for how long? Who gave the diagnosis?			
Other (specify):			

Please provide the names, addresses and phone numbers of Counselors Psychiatrists Therapists & other specialists that you are currently seeing or have seen in the past.

Name **Address** **Phone No.** **Reason**

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CARDIOVASCULAR*: Have you ever had or do you now have any of the following illnesses or problems with your heart or blood vessels?*	**No**	**Yes Past**	**Yes Current**
Heart Attack			
Angina Pectoris			
Heart Murmur			
Enlarged Heart			
Stroke			
High Blood Pressure			
Other problems with blood pressure			
Episodes of chest pains, tightness, discomfort			
Rheumatic Heart Disease			
Arteriosclerosis			
Varicose Veins			
Have you ever had heart surgery? , If yes please specify:			
Other (specify):			

DIGESTIVE SYSTEM: Have you ever had or do you now have any of the following illnesses or problems with your digestive system?	**No**	**Yes Past**	**Yes Current**
Are you on a special diet prescribed by a medical doctor? (Please attach doctor's orders)			
Blood in stool?			
Stomach or Duodenal Ulcer			
Appendicitis			
Nervous Stomach			
Colitis			
Frequent constipation			
Crohn's Disease			
Gastric Reflux Disease			
Frequent diarrhea			
Stomach pain			
Hiatal hernia or rupture			
Diverticulitis			
Hemorrhoids or piles			
Other(specify)			

RESPIRATORY ILLNESS/CONDITIONS: Have you had or do you now have any of the following illnesses or problems with your lungs?	**No**	**Yes Past**	**Yes Current**
Lung or Breathing difficulties or Shortness of Breath			
Asthma			
Emphysema			
Pneumonia			
Tuberculosis			
Bronchitis			
Pleurisy			
COPD			
Have you ever had surgery on your lungs? (If yes, describe):			
Do you use a C-PAP Machine?			
Other (specify):			

ENT: Have you ever had or do you now have any of the following problems with your **mouth, nose** or **throat**?	**No**	**Yes Past**	**Yes Current**
Nasal passages frequently irritated			
Nose bleeds often			
Throat is often irritated			
Voice is hoarse when you do not have a cold			
Mouth/Gums frequently have sores/ulcers			
Gums shrinking, irritated or bleeding			
Sinusitis			
Other (specify):			

LIVER AND SPLEEN: *Have you ever or do you now have any of the following illnesses or problems with your liver, spleen, or gallbladder?*	**No**	**Yes Past**	**Yes Current**
Cirrhosis of the liver			
Hepatitis			
Jaundice			
Gallbladder disease			
Gallbladder stones			
Injury to your spleen			
Have you ever had surgery on your liver or spleen? (If yes, describe):			
Other (Specify):			

ENDOCRINE: *Have you ever had or do you now have any of the following illnesses or conditions?*	**No**	**Yes Past**	**Yes Current**
Hypoglycemia			
Diabetes			
Goiter			
Thyroid disease or disorder			
Swollen glands or nodes			
Pancreatitis			
Other gland problems (specify):			

KIDNEYS/URINARY TRACT: *Have you ever had or do you now have any of the following illnesses or problems with your kidneys or urinary tract?*	**No**	**Yes Past**	**Yes Current**
Blood in urine			
Pain or burning when urinating			
Kidney disease			
Kidney infection			
Kidney stones			
Nephritis (Bright's Disease)			
Bladder Infection			
Prostate gland enlargement/infection (Males only)			
Tumor in urinary tract			
Have you ever had surgery on your kidneys or urinary tract? (If yes, describe):			
Other (specify):			

Gynecological\Reproductive Tract: *Have you ever had or do you now have any of the following illnesses or problems?*	**No**	**Yes Past**	**Yes Current**
Pelvic pain (PID)			
Endometriosis			
Cervicitis			
Uterine fibroids			
Painful periods			
Irregular periods			
Abnormal bleeding (If yes, please describe)			
Menopause			
Other (specify):			

REPRODUCTIVE HISTORY (Please answer all four questions):

a. Have you or your partner ever had a problem conceiving a child?
   __ No __ Yes
   If yes, __ Self __Present Partner __Previous Partner

b. Have you or your partner consulted a physician for fertility or other reproductive problems?
   __ Yes __ No
   If yes, specifically who consulted the physician? : __ Self __ Partner __ Self and Partner
   If yes, specify the diagnosis: ____
   ____

c. Have you or your partner ever conceived a child resulting in a miscarriage or still-birth?
   __ No __Yes If yes, __ Miscarriage __ Still Birth __ Deformed Offspring.
   If outcome was a deformed offspring, what was the deformity? ___________________________
   ____

d. Was this outcome a result of a pregnancy with your: __ Present Partner __ Prior Partner

e. Did the timing of any abnormal pregnancy outcome coincide with your present employment?
   __ Yes __ No

NERVOUS SYSTEM: *Have you ever had or do you now have any of the following illnesses or problems with your nervous system?*	**No**	**Yes Past**	**Yes Current**
Frequent headaches			
Migraine headaches			
Epilepsy, convulsions, seizures			
Nervous breakdown			
Loss of memory (amnesia)			
Nervousness			
Tremor of the hands or head			
Palsy or tremors			
Severe head injury			
Neuritis			
Paralysis of any type			
Sleep Apnea			
Insomnia			
Multiple Sclerosis			
Other problems (specify):			

BLOOD: *Have you ever had or do you now have any of the following blood diseases or problems?*	**No**	**Yes Past**	**Yes Current**
Anemia			
Low hemoglobin			
Bleeding disorder			
Leukemia			
Sickle cell disease or trait			
Phlebitis			
Have you ever had a blood transfusion?			
Other problems (specify):			

ALLERGIES: *Have you ever had or do you now have any allergies to the following:*	**No**	**Yes Part**	**Yes Current**
Medications (if yes, please list):			
Any food items (if yes, please list):			
Soaps or detergents			
Chromium			
Nickel			
Rubber			
Epoxy resins			
Plants (e.g., poison ivy, etc.)			
Pollen			
Insect scales			
House dust			
Animal dander, feathers, or fur			
Sunlight or cold			
Other (If yes, please list):			
Do you react with?			
Rash			
Hives			
Hay fever symptoms			
Breathing difficulty			
Other (If yes, describe):			

BONES AND JOINTS: *Have you ever had or do you now have any of the following problems with your bones or joints?*	**No**	**Yes Past**	**Yes Current**
Arthritis or Rheumatism			
Gout			
Joint pains			
Bone infections			
Bursitis or tendonitis			
Backache, back trouble , sciatica			
Trouble, flat feet or fallen arches			
“Trick”, “locked”, or “loose” knee			
Back injury or herniated disk			
Low Back Pain			
Painful or trick shoulder			
Swollen or painful joints			
Have you ever had surgery (including setting of broken bones) on any of your bones or joints (if yes, describe):			
Other problems with your bones or joints (if yes, please specify):			

SKIN: *Have you ever had or do you now have any of the following skin disorders?*	**No**	**Yes Past**	**Yes Current**
Hives			
Eczema			
Psoriasis			
Rash on elbows, knees, or scalp			
Rash other than on elbows, knees, or scalp			
Severe stubborn dandruff			
Small itching blisters on the side of your fingers or palms			
Excessive sweating on palms, soles, or armpits			
Sores that do not heal			
Moles that bleed or get larger			
Change in color of skin (other than suntan)			
New growth on skin			
Other (If yes, describe):			

EARS: *Have you ever had or do you now have any of the following problems with your ears or your hearing?*	**No**	**Yes Past**	**Yes Current**
Difficulty in hearing			
Tinnitus (ringing/buzzing) in right ear			
Nasal allergy			
Vertigo (dizziness)			
Perforation of the ear drum			
Ear drainage (caused by infection or injury)			
High fever			
Infection of inner ear			
Hearing loss by blood relatives (such as grandparents, parents, aunts, uncles, brother, or sisters) before they reached the age of 60			
Other problems with your ears (If yes, describe):			

EYES: *have you ever had or do you now have any of the following problems with your eyes or your vision?*	**No**	**Yes Past**	**Yes Current**
Glaucoma			
Cataracts			
Conjunctivitis			
Blurring of eyesight			
Vision getting worse			
Seeing double			
Seeing halos around lights			
Pain in the eyeball			
Eyes are often bloodshot			
Left eye Injured (e.g.; scratched, burned, cut, etc.)			
Right eye Injured (e.g., scratched, burned, cut, etc.)			
Left eye –Foreign object accidentally embedded in the eye			
Right eye-Foreign object accidentally embedded in the eye			
Do you wear glasses?			
Do you wear contact lenses?			
Other problems with your eyes (If yes, describe):			

CANCER: Have you ever been diagnosed with cancer? (*If yes, list the year and type of diagnosis.)*		
Type	**Year**	**Specific Tissue Diagnosis (If available)**
Skin		
Colon		
Breast		
Lung		
Prostate		
Testicular		
Cervical		
Uterine		
Other (*If yes, specifically type and describe tissue diagnosis and year):*		

INFECTIOUS/CHILDHOOD DISEASES: *Have you had or do you now have:*	**No**	**Yes Past**	**Yes Current**
Mononucleosis			
Meningitis			
Malaria			
Polio			
Rheumatic fever			
Scarlet fever			
Mumps			
Measles			
Chicken pox			
German measles			
Tonsillitis			
Gonorrhea			
Syphilis			

FAMILY HISTORY: *Have any of your blood relatives (parents, grandparents, brothers, sisters, aunts, uncles or children) had any of the following illnesses or conditions?*	**No**	**Yes Past**	**Yes Current**
Anemia			
Alcoholism			
Allergies			
Arthritis			
Asthma			
Bleeding disorders (free bleeder)			
Breast cancer			
Cervical cancer			
Chronic bronchitis			
Congenital malformations (birth defect)			
Diabetes (sugar)			
Digestive or bowel disease			
Eczema			
Emphysema			
Epilepsy			
Glaucoma			
Gout			
Hay Fever			
Heart Attack			
Heart Disease			
High blood pressure			
Kidney or bladder disease			
Kidney stones			
Liver or gallbladder disease			
Lung cancer			
Mental illness			
Mental retardation			
Nervous system disease			
Psoriasis			
Sickle cell disease or trait			
Stroke			
Thyroid disease			
Tuberculosis (T.B.)			
Ulcer (stomach, duodenal, peptic)			
Other cancers or leukemia			

MEDICATIONS: *Have you taken any of the following medications?*	**No**	**Yes Past**	**Yes Current**
Antacids			
Antibiotics (e.g., penicillin, ampicillin, tetracycline)			
Antihistamines			
Aspirin			
Benzedrine/Dexedrine			
Birth control pills			
Blood thinners (anti-coagulants)			
Codeine			
Cortisone or other steroids			
Diet pills			
Digitalis or other heart pills			
Diuretic or water pills			
Hormones			
Insulin or oral anti-diabetic drugs			
Iron pills			
Laxatives			
Morphine			
Nitroglycerine			
Pain Killers (aspirin, empirin, anacin, bufferin, etc.)			
Pep pills or Mood elevators			
Pills to lower your blood pressure			
Sleeping pills			
Sulfa preparations			
Thyroid medication			
Tranquilizers, sedatives, or nerve pills			
Vitamins			
Others			

IMMUNIZATIONS, VACCINES, ANTITOXINS: *Have you had any of the following immunizations?*	**No**	**Yes Past**	**Yes Current**
Tetanus			
Poliomyelitis (Polio)			
Influenza			
Typhoid			
Diphtheria			
Rabies			
Rubella (German measles)			
Measles (Rubeola or red measles)			
BCG			
Yellow Fever			
Smallpox			
RhoGAM (*Ri immune globulin*)			
Mantoux, patch test, or other skin test for tuberculosis			
Other: (Please list)			

History of Hospitalization: Have you ever been hospitalized? __ No __ Yes

(If yes, list reason(s) and date(s) of hospitalization.)

Reason: ____________________________________ *Date:* ______________________________

____________________________________ ______________________________

____________________________________ ______________________________

____________________________________ ______________________________

Are you aware of any other disease or illnesses that run in your family that have not already been listed? (If yes, please list below):

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Do you have any problems you would like to discuss with the doctor? __No __Yes

(If yes, please list them):

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Signature: _____________________________________ Date Completed: _______________