MEDICAL HISTORY QUESTIONNAIRE

*Please print clearly and complete **all** fields to the best of your knowledge.*

Patient's Name: _____ Age: _____ Today's Date:_____
Reason for today's visit: _____

Do you have an Advance Directive such as a Living Will, a Durable Power of Attorney (DPA) for Healthcare, or a Do Not Resuscitate (DNR) order?_____

MEDICAL ILLNESSES:

[ ]None	[ ]Diabetes	[ ]High Blood Pressure
[ ]Stroke	[ ]Heart Attack	[ ]Heartburn
[ ]Asthma	[ ]Allergies	[ ]Thyroid
[ ]Migraines	[ ]Depression	[ ]Other psychiatric

[ ]Other_____

SURGERIES:

[ ]hernia	[ ]tonsils	[ ]adenoids	[ ]knee	[ ]ear tubes
[ ]appendix	[ ]tubal ligation	[ ]C-section	[ ]hysterectomy	

[ ]Other_____ [ ]Other Hospitalizations_____

MEDICATIONS / PRESCRIPTIONS:

[ ]None [ ]Vitamins [ ]Supplements [ ]Herbs

Name:	Strength:	Frequency:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

ALLERGIES:

[ ]None [ ]Penicillin [ ]Sulfa [ ]Other:_____

FAMILY HISTORY: List any medical problems (Examples found under Medical Illnesses section above)

1. Mom:_____
2. Dad:_____
3. Siblings:_____
4. Maternal Grandmother:_____
5. Maternal Grandfather:_____
6. Paternal Grandmother:_____
7. Paternal Grandfather:_____

SOCIAL HISTORY:

Marital Status: [ ]single	[ ]married	[ ] divorced	[ ]widowed	[ ]other:_____
Children:_____	Siblings:_____		Pets:_____	
Tobacco:_____	Alcohol:_____		Drugs:_____	
Occupation:_____	Exercise:_____		Caffeine:_____	