

Patient History Questionnaire

Patient Last Name _____ First _____ Middle _____
Birth Date: _____ Age: _____ Male Female

Referring Physician: _____ Family Physician: _____

Reason for Visit: _____

Allergies (List): _____

Medications (List): _____

Medical History: *Please check next to yes or no if you have any of the following medical problems:*

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV / AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Other Medical Problems: _____

Past Surgical History &/or Hospitalizations: *Please list surgeries and approximate dates*

Social History:
Marital Status: Single Married Separated Divorced Widowed
Tobacco Use: Never Smoked Smoke (# packs per day _____ / Yrs Smoked _____) Quit (Date _____)
Alcohol Use: Never Rarely Moderate Daily (# of drinks per day _____)

Family Medical History: *(heart disease, diabetes, cancer, stroke, etc.)*

Father: _____ Mother: _____

Sibling: _____ Other: _____

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Patient Signature Date Reviewed by (Physician / Nurse Initials)