FOR OFFICE USE ONLY

MRN #_____

Please Use **Black Ink** or Type

Medical History Questionnaire – Page 1

Name: _____ **DOB:** _____ **Age:** ____ **Today's Date:** _____
Last First Middle

Referring Physician: _____ **Primary Care Physician:** _____

Chief Complaint / Reason for Visit: _____

Drug Allergies: (please include type of reaction) ☐ yes ☐ no

Drug Name _____ Reaction _____
Drug Name _____ Reaction _____
Drug Name _____ Reaction _____

☐ Latex Allergy ☐ Contrast / IVP Dye / Shellfish Allergy

Pharmacy Name, Address, phone number: _____

Medication List: ☐ None
(list names, dosages and frequency of all medications including aspirin, OTC meds and vitamins)

_____ _____
_____ _____
_____ _____
_____ _____

Past Medical History: (please circle all that apply)

Alcoholism	Depression	Melanoma
Anemia	Diabetes Mellitus	Myocardial infarction (Heart attack)
Anxiety	DVT	Pacemaker
Arthritis	Emphysema	Pulmonary embolism
Asthma	GERD (Reflux)	PVD (Artery blockage or artery disease)
Atrial Fib	Glaucoma	Seizures
Cancer & type	Heart murmur	Sleep Apnea
Clotting disorder	Hemorrhoids	Stroke / ministroke
Colon polyps	Hepatitis	Substance abuse
Congestive Heart Failure (CHF)	HIV/AIDS	Thyroid disease
COPD	Hyperlipidemia (High cholesterol)	Ulcers
Coronary Artery Disease (heart disease)	Hypertension (High blood pressure)	**OTHER:**
Crohn's Disease / Ulcerative Colitis	Kidney disease	**OTHER:**

Past Surgical History: (please note approximate date of surgery)

Appendectomy	Cosmetic surgery	Spine surgery
Brain surgery	C-Section	Thyroid Surgery
Breast surgery	Hernia repair	Tubal ligation (Tubes tied)
Bypass (Artery surgery)	Hysterectomy	Valve replacement
CABG (Open heart surgery)	Joint replacement & type	Vasectomy
Cholecystectomy (Gallbladder removal)	Prostate surgery	**OTHER:**
Colon surgery	Small intestine surgery	**OTHER:**

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Medical History Questionnaire – Page 2

Name: _____ **DOB:** _____
Last First Middle

Prior Workup / Diagnostic Tests

	Yes / Date	No	Physician
Colonoscopy			
Barium Enema			
Flexible Sigmoidoscopy			
Mammogram			

Family History:

Relationship	Status A= Alive D=Deceased		COPD	Crohn's Disease	DVT	Diabetes	Early Death	Heart Disease	High Blood Pressure	Stroke	Ulcerative Colitis	Cancer	Type of Cancer					
Mother																		
Father																		
Sister																		
Brother																		
Daughter																		
Son																		

Family History: (please circle medical illnesses/conditions that occur in your family):

	Relationship		Relationship
MI (heart attack)		Anesthesia Problems	
Bleeding Problems		Hyperparathyroidism	
Colon / Rectal Cancer		Hypercalcemia	
Colon / Rectal Polyps		Pheochromocytoma	
Breast Cancer			

Social History:

Alcohol Use: ☐ yes ☐ no

_____ Glasses of wine/week
_____ Cans of beer/week
_____ Shots of liquor/week
_____ Drinks containing 0.5 oz of alcohol /week

Patient Name:_____

DOB:_____

(or use patient label)

Name / MR # / Label

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MRN #_____

Medical History Questionnaire – Page 3

Name: _____ **DOB:** _____
Last First Middle

Tobacco Use: ☐ yes ☐ no
_____ Cigarettes _____ Other tobacco _____ Years _____ Packs/day _____ Ready to Quit
_____ Former Tobacco Use _____ Quit Date

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Children: ☐ yes ☐ no **Ages:** _____

Review of Systems: Please circle below if you ***currently*** have ***any*** of the following problems. ☐ None currently apply

CONSTITUTIONAL	**RESPIRATORY**	**GU**	**SKIN**
Activity change	Apnea	Difficulty urinating	Color change
Appetite change	Chest tightness	Dysuria (Burning or pain with urination)	Pallor (Paleness of skin)
Chills	Choking	Enuresis (Inability to control urine)	Rash
Diaphoresis	Cough	Frequency	Wound
Fatigue (Tired)	Shortness of breath	Genital sore	**NEUROLOGICAL**
Fever	Stridor	Hematuria (Blood in urine)	Dizziness
Unexplained wgt. Change	Wheezing	Penile discharge	Seizures
HENT	**CARDIOVASCULAR**	Penile pain	Speech difficulty
Facial swelling	Chest pain	Penile swelling	Syncope (Fainting spells)
Hearing loss	Leg swelling	Scrotal swelling	Tremors
Dental problem	Palpitations	Testicular pain	Weakness
Mouth sores	**GI**	Urgency	**HEMATOLOGIC**
Sore throat	Abdominal distention	Urine decreased	Adenopathy (Lymph system)
Trouble swallowing	Abdominal pain	**MS**	Bruises/bleeds easily
Voice change	Anal bleeding	Arthralgias (Pain in joints)	**PSYCHIATRIC**
EYES	Blood in stool	Back pain	Agitation
Eye discharge	Constipation	Gait problem (Trouble walking)	Confusion
Eye pain	Diarrhea	Joint swelling	Hallucinations
Visual disturbance	Nausea	Myalgias (Pain in muscles)	Nervous / anxious
	Rectal pain	Neck Pain	Suicidal ideas
	Vomiting	Neck Stiffness	

Patient Signature: _____ **Date:** _____ **Time:** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)