MEDICAL HISTORY QUESTIONNAIRE

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General Information

Patient's Name: ______________________________ Date: ______________

Birth Date: __________ Age: _____ Sex: Male Female Social Security Number: ______________

Address: ______________________________

City: ______________ State: _____ Zip: ______________

Home Phone: ______________ Business Phone: ______________

Cell Phone: ______________ Email Address: ______________

Marital Status: Married Single Divorced Widowed Separated

Name of Spouse: ______________ Birth Date: ______________

Spouse's Employer: ______________ Business Phone: ______________

Cell Phone: ______________

Patients Occupation: ______________________________

Position: ______________ Employer: ______________

Address: ______________________________

Phone: ______________________________

Insurance Company: ______________________________

Address: ______________ Phone Number: ______________

Family Physician and/or Primary Health Care Provider:

Doctor/Other: ______________ Phone: ______________

Address: ______________ City: ______________

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

☐ Yes ☐ No

Name of Referring Physician: ______________________________

Is this visit injury related? ☐ Yes ☐ No

If yes, please check: Work ____ Auto ____ Date of Injury: ______________

PLEASE BRING INSURANCE CARDS TO THE FRONT WINDOW TO BE COPIED

Signature: ______________________________ Date: ______________

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions?

☐ **NONE**

___ Alcoholism/ Drug Abuse
___ Anxiety
___ Arrhythmia (Atrial Fibrillation)
___ Arrhythmia (Other)
Type: ______________________________
___ Arthritis (Rheumatoid)
___ Arthritis (Osteoarthritis)
___ Asthma
___ Bleeding Problems
___ Blood Clot (leg)
___ Blood Clot (lung)
___ Cancer
Type: ______________________________
___ Cataracts
___ Congestive Heart Failure
___ Coronary Artery Disease
___ Depression
___ Diabetes
___ Diverticulosis
___ Emphysema / COPD
___ Epilepsy /Seizures
___ Fibromyalgia
___ Fractures (broken bones)
Where:______________________________
___ Gallbladder disease
___ Gastroesophageal Reflux (Heartburn/GERD)
___ Glaucoma
___ Gout / Pseudogout

___ Heart Attack
___ Heart Stents
___ Hepatitis
___ High Blood Pressure
___ High cholesterol
___ Irritable bowel syndrome
___ Kidney Disease / Failure
___ Kidney Stones
___ Liver Disease
___ Lung disease
Type: ______________________________
___ Migraine Headaches
___ Osteoporosis
___ Prostate (enlargement)
___ Prostate (nodules)
___ Rheumatic Fever
___ Skin Condition (Eczema)
___ Skin Condition (Psoriasis)
___ Sleep apnea
___ Stomach Ulcer
___ Stroke or TIA
___ Thyroid (nodule)
___ Thyroid High (Overactive) / Hyperthyroidism
___ Thyroid Low (Underactive) / Hypothyroidism
___ Tuberculosis
___ Vascular Disease (Carotid)
___ Vascular Disease (Lower extremity)
___ Yellow Jaundice
___ Other (please list):

SURGICAL HISTORY: Please check off any procedure or surgeries. ☐ **NONE**

Surgical Procedure	***Yes***	***Year***	***Comments***
Abdominal Surgery			
Aneurysm Repair			
Appendectomy (appendix removal)			Circle: Laparoscopic
Back Surgery			
Bariatric			
Biopsy			
Breast Biopsy			Circle: Right Left Both
Breast Surgery			Circle: Right Left Both
Cardiac Bypass (CABG)			
Carotid Endarterectomy (cleaned out)			
Cataract			
Colonoscopy			
Coronary Stent			
EGD (Stomach Endoscopy)			
Gallbladder Removal			Circle: Laparoscopic
Heart Surgery (other than coronary bypass / CABG)			
Hip Fracture			Circle: Right Left Both
Hip Replacement			Circle: Right Left Both
Hysterectomy (total, including ovaries)			
Hysterectomy (partial, ovaries left)			

Knee Arthroscopy (scope)			Circle: Right Left Both
Knee Replacement			Circle: Right Left Both
Neck Surgery			
Ovary Ligation ("Tubal")			
Ovary Removal			Circle: Right Left Both
Prostate Surgery			Circle: Removed TURP
Vascular Bypass Graft in Legs			Circle: Right Left Both
Vasectomy			
Vein Stripping			
Other (please list):			

SOCIAL HISTORY:

Tobacco Use
Smoke cigarettes: ☐ Never ☐ No ☐ Yes
(If you never smoked please go to alcohol use question now)
Quit date: _______
How many years did you smoke? ________
Approximately how many packs a day did you smoke? ________
Current smoker: Packs/day: __________ # of years: __________
Other tobacco: ☐ Pipe☐ Cigar ☐ Chew

Alcohol Use
Do you drink alcohol? ☐ Yes ☐ No
# of drinks/week: ____________ ☐ Beer ☐ Wine ☐ Liquor

Drug Use
Do you use marijuana or recreational drugs? ☐ Yes ☐ No

Other
Please list the people you currently live with:____

Can you walk up one flight of stairs without difficulty? ☐ Yes ☐ No

What is your occupation? ____________________________ Does it involve any lifting? ☐ Yes ☐ No

Do you feel safe in your home? ☐ Yes ☐ No

FAMILY HISTORY: Indicate which relative has had the following diseases (parents and siblings are most important).

Adopted – ☐ Yes ☐ No
If yes and you do not know your family history skip this section and continue to medications.

Disease	***Yes***	***Relative***
Alzheimer's		
Arthritis		
Autoimmune Disease		
Bleeding or Clotting Disorder		
Cancer (please list type with relative)		
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Reaction to Anesthesia		
Other		

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

☐ **TAKING NO MEDICATIONS**

Name of Medication	Dose (e.g., mg/pill)	How Often?

ALLERGIES: Allergies or intolerance to medications (include type of reaction): ☐ **NONE**

Latex allergy? ☐ Yes ☐ No

REVIEW OF SYSTEMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check “no problems” if none of the symptoms apply to you. List other concerns above.

General ___ Unexplained weight loss ___ Unexplained weight gain ___ Unexplained fatigue / weakness ___ Fever ___ Chills **___ No problems** *Skin* ___ Rash / itching **___ No problems** *Ears/Nose/Throat* ___ Nosebleeds ___ Trouble swallowing ___ Frequent sore throat, hoarseness ___ Hearing loss / ringing in ears **___ No problems** *Eyes* ___ Change in vision / eye pain / redness ___ Yellow eyes **___ No problems**	*Cardiovascular* ___ Chest pain / discomfort ___ Palpitations (fast or irregular heartbeat) ___ Ankle swelling **___ No problems** *Respiratory* ___ Cough / wheeze ___ Snoring ___ Shortness of breath **___ No problems** *Gastrointestinal* ___ Heartburn / reflux / indigestion ___ Abdominal pain ___ Nausea / vomiting ___ Diarrhea ___ Blood or change in bowel movement ___ Constipation **___ No problems** *Genitourinary* ___ Leaking urine ___ Blood in urine ___ Nighttime urination or increased frequency ___ Difficulty urinating ___ Pain with urination **___No problems** *Musculoskeletal* ___ Neck pain ___ Back pain ___ Muscle / joint pain ___ Muscle weakness **___ No problems**	*Endocrine/Lymph/Hematologic* ___ Heat or cold sensitivity ___ Excessive thirst ___ Easy bruising/bleeding ___ Swollen glands **___ No problems** *Neurological* ___ Headache ___ Memory loss ___ Fainting ___ Dizziness ___ Numbness / tingling ___ Unsteady gait ___ Frequent falls **___ No problems** *Allergic/Immune* ___ Hay fever / allergies ___ Frequent infections **___ No problems** *Psychiatric* ___ Anxiety / stress / irritability ___ Sleep problem **___ No problems**

Authorization for Release of Information to Family Member or Friend Without Power of Attorney

I ____________________(patient), hereby give the following person

or person's authorization to obtain information regarding my:

__ Confirm appointments and leave messages
__ Lab Work / Test Results
__ Medical Records Information
__ Billing Information
__ All of the above

Person 1: ________________________Relationship________________

Person 2: ________________________Relationship_______________

Person 3: ________________________Relationship________________

Person 4: ________________________Relationship_______________

Person 5: ________________________Relationship________________

Patient Signature: ____________________________ Date___________

Notice of Privacy Practices Acknowledgement

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as assessments and physician certifications.**

I have received read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name____

Relationship to Patient if Unable to Sign_________________________________

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below: