

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DATE:** _____

My ability to assess your present state of health and how to improve it depends on your ability to respond thoughtfully and accurately to both these written questions and my oral questions. Health is usually influenced by many factors, including lifestyle, potential toxic exposures, and genetics. Your careful consideration of each of the following questions will enhance our efficiency and make more effective use of your scheduled office visit time. ***(All information is kept strictly confidential.)***

1. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age 7, sister _____

2. Do you have any pets or farm animals? Yes___ No___

If yes, where do they live? 1. ___ indoors 2. ___ outdoors 3. ___ both indoors & outdoors

3. Have you lived or traveled outside of the United States? Yes___ No___

If so, when and where? _____

4. Have you or your family recently experienced any major life changes? Yes___ No___

If yes, please comment: _____

5. Have you experienced any major losses in life? Yes___ No___

If so, please comment: _____

6. How important is religion or spirituality for you and your family's life?

- a. ___ not at all important
- b. ___ somewhat important
- c. ___ extremely important

7. How much time have you lost from work or school in the past year?

- a. ___ 0-2 days
- b. ___ 3-14 days
- c. ___ > 15 days

8. Previous jobs: _____

9. Past Medical and Surgical History:

<u>ILLNESSES</u>	YEAR(S)	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
Gout		
Heart attack/Angina		
Heart failure		
Hepatitis		
High cholesterol or triglycerides		
High blood pressure		
Irritable bowel		
Kidney stones		
Mononucleosis		
Pneumonia		
Rheumatic fever		
Sinusitis		
Sleep apnea		
Stroke		
Thyroid disease		
Others (describe)		
<u>INJURIES</u>	YEAR(S)	COMMENTS
Back injury		
Broken (describe)		
Head injury		
Neck injury		
Others (describe)		
Others (describe)		
<u>DIAGNOSTIC STUDIES</u>	YEAR(S)	COMMENTS
Barium Enema		
Bone Scan		

Chest X-ray		
Colonoscopy		
CT or MRI Scan of Abdomen		
CT or MRI Scan of Chest		
CT or MRI Scan of Brain		
CT or MRI Scan of Spine		
EKG		
Liver scan		
Neck X-ray		
Sigmoidoscopy		
Upper GI Series		
Others (describe)		
Others (describe)		

OPERATIONS	YEAR(S)	COMMENTS
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Others (describe)		
Others (describe)		

10. Hospitalizations:

WHERE HOSPITALIZED	YEAR(S)	FOR WHAT REASON
a.		
b.		
c.		
d.		

11. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teens		
Adulthood		

12. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	> 5 times
Infancy/ Childhood		
Teens		
Adulthood		

13. Are you allergic to any medications? Yes___ No___

If yes, please list: _____

14. What medications are you taking now? (Include non-prescription, skin & eye drugs.)

Medication Name	Date started	Dosage & Comments
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

15. List all vitamins, minerals, and other nutritional supplements that you are taking now.

Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	When started	Dosage & Comments
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

16. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar &/or sweets?				

17. As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes___ No___

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)
