MEDICAL HISTORY QUESTIONNAIRE

Name: D.O.B. Date:

Please check all that apply.

PERSONAL HEALTH HISTORY

- ☐ Arthritis
- ☐ Allergies/Hay Fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Autoimmune Disease
- ☐ Blood Clotting Disorders
- ☐ Blood Pressure Problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Genetic Disease
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Infection, Chronic
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Learning Disabilities
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Seasonal Affective Disorder
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Imbalance
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract Infections

MEN

- ☐ Benign Prostatic Hyperplasia
- ☐ Decreased Sex Drive
- ☐ Frequent Urination
- ☐ Infertility
- ☐ Prostate Cancer
- ☐ Sexually Transmitted Disease
- ☐ Other _____

FAMILY HEALTH HISTORY

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorders
- ☐ Heart Disease
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Other _____

WOMEN

Answer only if applicable

Age at First Period_____

Age at Menopause_____

Date LMP_____

Length of Cycle_____Days

Female Surgeries_____

_____

Date of Last Mammogram

_____

Date of Last Pap_____

# of Children_____

# of Pregnancies_____

C-Sections_____

Form of Birth Control

_____

- ☐ Menstrual Irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibroid Cysts – Breasts
- ☐ Fibroid Cysts – Ovaries
- ☐ Premenstrual Syndrome (PMS)
- ☐ Breast Cancer
- ☐ Pelvic Inflammatory Disease
- ☐ Vaginal Infections
- ☐ Decreased Sex Drive
- ☐ Sexually Transmitted Disease
- ☐ Other _____

OTHER HISTORY

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