

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____

Date: _____

Family Doctor: _____

Date of Birth: _____

Today's Problem: _____

Do you have any medical problems?

Habits/Amounts:

No Yes

Tobacco How Much _____

Alcohol How Much _____

Caffeine How Much _____

Street Drugs How Much _____
(Cocaine, Narcotics, Marijuana, etc.)

Special Diet? _____

Medications you take now: _____

Any past illnesses/medical conditions?

- Stroke Diabetes High Cholesterol
 Cancer High Blood Pressure

Any past surgeries and when:

- Tonsils Appendix Gall Bladder
 Heart Surgery Hysterectomy

Any recent accidents and when: _____

Allergies: _____

Family History: (age, illnesses, living/deceased for each family member)

Mother: _____

Father: _____

Children: _____

Sister/Brother: _____

Significant Illness in Extended Family (Grandparents, Aunts, Uncles, Cousins) (circle all that apply):

- Stroke High Blood Pressure Diabetes Mellitus High Cholesterol Kidney Disease
Cancer Heart Disease Glaucoma

Other: _____