

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

WHY ARE YOU HERE TODAY: _____

Review of Systems:

Do you **presently** have any problems in the following areas? If "yes" give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
CONSTITUTIONAL (fever, weight loss)	()	()	_____
EYES (trouble with vision)	()	()	_____
EARS, NOSE, THROAT	()	()	_____
CARDIOVASCULAR (heart, blood vessels)	()	()	_____
RESPIRATORY (lungs/breathing)	()	()	_____
GASTROINTESTINAL (stomach/intestines/liver)	()	()	_____
GENITOURINARY (genitals/kidneys/bladder)	()	()	_____
MUSCULOSKELETAL (muscles/joints)	()	()	_____
DERMATOLOGICAL (skin)	()	()	_____
PSYCHIATRIC	()	()	_____
SLEEP: Snoring or Excessive Daytime Sleepiness	()	()	_____
Do your legs make it difficult to fall asleep?	()	()	_____
ENDOCRINE (hormones/glands)	()	()	_____
HEMATOLOGIC/IMMUNOLOGIC (blood)	()	()	_____
ONCOLOGICAL (cancer)	()	()	_____

PAST HISTORY (MEDICAL)

List any medications that you are currently using: _____

List all major illnesses: Diabetes: _____ Hypertension: _____

Other: _____

List any major surgical procedures : _____

DO YOU HAVE ANY MEDICATION ALLERGIES: () NO () YES Penicillin Sulfa

List other medication allergies: _____

Patient's signature: _____ Date _____

History reviewed
Physician's signature _____ Date _____