

Medical History Questionnaire

Patient Name: _____ **Today's Date:** _____
(Print) Last First MI
Birthdate: _____ **Age:** _____ **Gender:** Male Female Twin Adopted **Accompanied by:** _____
Yr./Mo
Primary Care Physician: _____ **Doctor who referred the patient:** _____
Other Physicians (specify): _____
Reason for Visit: _____

Medical Conditions:

Has the patient ever been diagnosed with any of the following?

Amblyopia (lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastroesophageal Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type: _____ When? _____		High Cholesterol or Lipids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strabismus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Environmental Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

List any other medical illness: _____

List any past surgeries or hospitalizations (please include year): _____

Fill out only if patient is a child under 5 years of age

Current Weight: _____ Birth Weight: _____ lbs. _____ ozs. or _____ gms. Number of Siblings: _____
 Premature at birth Yes No If yes, born at _____ weeks, why? _____ Brothers: _____ Ages: _____
 Grade in School: _____ School Attending: _____ Sisters: _____ Ages: _____
 ADHD/ADD Yes No Failure to Thrive Yes No Oxygen after birth Yes No
 Daycare Yes No Growth Delays Yes No Speech Delay Yes No
 Class Size: _____ Household Smoker Yes No Drug use during pregnancy Yes No
 Development Delay Yes No Low % on growth chart Yes No Alcohol use during pregnancy Yes No

Drug Allergies:

No Yes If yes, list drug allergies and how you reacted: _____

List current medications (i.e. over the counter medications, herbs, vitamins, aspirin, coumadin, etc): See Attached List List continued on back

Family Health History:

Amblyopia (lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Environmental Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strabismus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/Seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family History Unknown Other Family Health History: _____

Social History:

Alcohol Usage Yes No Quit _____ Exposure to second hand smoke Yes No
 Cigarette Smoking Yes No Quit _____ Live alone Yes No
 Chewing Tobacco Yes No Quit _____ Occupation: _____

Review of Systems:

Please check all symptoms which the patient has currently, or has had recently. Check YES, please explain on the back..

General (ex: unintentional weight change)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal (ex: reflux)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood (ex: bruising)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear, Nose, or Throat (ex: hearing loss, snoring)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney (ex: stones)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine (ex: thyroid)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye (ex: blurry vision)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone, Joint, or Muscle (ex: arthritis, joint swelling)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart (ex: chest pain, murmurs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin (ex: masses, lesions)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric (ex: anxiety, depression)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung (ex: wheezing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological System (ex: seizures, convulsions, headaches)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADD, ADHD)	