



ADULT MEDICAL HISTORY QUESTIONNAIRE

Please complete both sides of this form so we are able to provide you with the best of care

Patient Name: _____ DOB: / / Age: _____
Please Print Last First
 Gender: Male Female
 Chief Complaint: _____
 Patient Accompanied By: _____

PHARMACY INFORMATION:	Name: _____	Phone: _____
	Address: _____	

Primary Care Provider: _____ Doctor who sent you here: _____

PAST MEDICAL HISTORY

<input type="checkbox"/> ADD	<input type="checkbox"/> Diabetes, Type II	<input type="checkbox"/> High Lipids	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Anemia	<input type="checkbox"/> Dizziness	<input type="checkbox"/> HIV	<input type="checkbox"/> Prior Sleep Study
<input type="checkbox"/> Anesthesia Problems	<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> Hoarseness	When: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Insomnia	Where: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gastric Reflux	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Snoring
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Headaches	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Cancer (skin, thyroid, etc) Type: _____	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Diabetes, Type I	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> TMJ Disorder
<input type="checkbox"/> No Pertinent History	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Restless Leg Syndrome	<input type="checkbox"/> Vascular Stents
<input type="checkbox"/> Other: _____			

PAST SURGICAL HISTORY

Please include dates of surgery

<input type="checkbox"/> Ear Surgery _____	<input type="checkbox"/> Neck Surgery (ie thyroid) _____	<input type="checkbox"/> Vocal Cord Surgery _____
<input type="checkbox"/> Facial Surgery _____	<input type="checkbox"/> Skin Lesion/Cancer Surgery _____	
<input type="checkbox"/> Nasal/Sinus Surgery _____	<input type="checkbox"/> Tonsillectomy/Adenoidectomy _____	
<input type="checkbox"/> Other _____		

MEDICATION HISTORY

List current medications and dosage: _____

DRUG ALLERGIES

Drug Allergies: No Known Drug Allergies Yes (if yes, please list and include reaction)

FAMILY MEDICAL HISTORY

<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid Cancer
<input type="checkbox"/> Cancer	<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease
Type: _____	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sleep Apnea	
<input type="checkbox"/> Family History Unknown <input type="checkbox"/> Other: _____			

(To complete, see reverse side)



SOCIAL HISTORY

Alcohol Usage

- Currently Every Day
Amount: _____ Type: _____
- Currently Some Days
Amount: _____ Type: _____
- Former Age Quit: _____
- Never

Tobacco Usage

- Currently Every Day
Amount: _____ Type: _____
- Currently Some Days
Amount: _____ Type: _____
- Former Age Quit: _____
- Never

Other

- Do you live alone? (check for yes)
- Prior or Current Recreational Drug Use
- Other Risk Factors for HIV
Explain: _____
- Occupation: _____

REVIEW OF SYSTEMS

Please check all symptoms which you have presently or have had recently. If you have not experienced a medical problem under the symptom listed, check the No box.

CONSTITUTIONAL SYMPTOMS

- fatigue fever difficulty sleeping

Other: _____

- No Constitutional Symptoms

EYE SYMPTOMS

- eye discomfort changes in vision

Other: _____

- No Eye Symptoms

CARDIOVASCULAR SYMPTOMS

- chest pain irregular heart beats
 lightheadedness

Other: _____

- No Cardiovascular Symptoms

RESPIRATORY SYMPTOMS

- shortness of breath hoarseness cough
 wheezing

Other: _____

- No Respiratory Symptoms

GASTROINTESTINAL SYMPTOMS

- nausea heartburn difficulty swallowing
 choking on liquids reflux

Other: _____

- No Gastrointestinal Symptoms

GENITOURINARY SYMPTOMS

- urgency pain or burning with urination
 urinary tract infection kidney stones

Other: _____

- No Genitourinary Symptoms

INTEGUMENT (SKIN) SYMPTOMS

- new skin lesions lumps change in mole appearance

Other: _____

- No Integument (skin) Symptoms

NEUROLOGIC SYMPTOMS

- speech difficulties migraines dizziness headaches
 seizures numbness/tingling weakness

Other: _____

- No Neurologic Symptoms

MUSCULOSKELETAL SYMPTOMS

- muscular weakness twitching gait changes
 joint pain

Other: _____

- No Musculoskeletal Symptoms

ENDOCRINE SYMPTOMS

- weight gain weight loss history of thyroid problems
 hot or cold intolerances

Other: _____

- No Endocrine Symptoms

PSYCHIATRIC SYMPTOMS

- anxiety depression

Other: _____

- No Psychiatric Symptoms

HEME(BLOOD)-LYMPH SYMPTOMS

- swollen lymph nodes easy bleeding or bruising

Other: _____

- No Heme(blood)-Lymph Symptoms

ALLERGIC-IMMUNOLOGIC SYMPTOMS

- environmental allergies immune deficiency

Other: _____

- No Allergic-Immunological Symptoms