Previous History Questionnaire

Thank you for allowing us to help you with your medical needs. In order to help you better, we need to know something about your past medical history, allergies, medications, etc. If you need additional space please do not hesitate to ask for more paper.

Current Medications: (Name , strength and how often)

1)_____ 5)_____
2)_____ 6)_____
3)_____ 7)_____
4)_____ 8)_____

Previous Hospital stays: (For what problem?, Surgeries ?, How long in hospital, which hospital.)

1)_____
_____
_____

2)_____
_____
_____

3)_____
_____
_____

4)_____
_____
_____ __

5)_____
_____
_____

OTHER MEDICAL PROBLEMS TREATED AS AN OUTPATIENT (Please list the diagnosis, when diagnosed, and whether or not this is still a problem.)

1_____
2)_____
3)_____
4)_____

Please list any medicine allergies:_____

Do you smoke? Yes___ No___ Quit_____(list year quit)
If so, how many packs per day? _____

Do you drink any alcoholic beverages ?_____. How much ? _____
(Please fill out both sides - this is page 1 of 2 pages)

Family History page 2

Please list the current health problems (if any) of any of the following living relatives. For those who are deceased, please give any health problems and cause of death if known.

MOTHER: Age____ Health_____

FATHER: Age_____ Health_____

BROTHERS (List Ages & Health status)

_____
_____
_____

SISTERS

_____
_____
_____

CHILDREN (Please list their ages & sex & health)

_____
_____
_____

OTHER RELATIVES (Who may have related diseases such as diabetes, thyroid problems, high blood pressure, heart problems, etc...)

_____
_____
_____

Social History:

Who else is in your household_____

What kind of work do you do_____

Are you exposed to any infections or toxins at work? _____

How much school have you completed_____

Are there any other health concerns that you have today?

_____
_____
_____

(If you filled out page 1 then you are done - Thank you !)