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Medical Questionnaire

Date:______________________________________

Name: ______________________________ Date of Birth:______________ Age:_________ Gender: ☐ M ☐ F

Marital Status:__________________________ # of Children:_______ Occupation:________________________

Race:____________________ Preferred Pharmacy Location: ______________________________________

Past Medical History: (check any of the following which you have or been treated for)

☐ High Blood Pressure ☐ Cardiac Disease ☐ Diabetes ☐ Cancer
☐ Liver Disease ☐ Kidney Disease ☐ Asthma/Emphysema ☐ Stomach Trouble
☐ Neurological Disorder (Stroke, etc) ☐ Arthritis (Joint Problems) ☐ Other______________________

Surgical Procedures	Year and Where	Hospitalizations	Year and Where

Regular Medications: **(including dosage and frequency; include prescription, over-the-counter, vitamins, birth control pills, etc.)**

____ ____
____ ____
____ ____
____ ____

Allergies to Medications: ____________________ ________________ ________________
Other Allergies: ____________________ ________________ ________________

Family History: (check all that apply)	Relation	Age it Occurred
☐ Hypertension		
☐ Heart attack		
☐ Strokes		
☐ Diabetes		
☐ Ovarian Cancer		
☐ Breast Cancer		
☐ Colon Cancer		
☐ Other Cancer		
☐ Tuberculosis		
☐ Glaucoma		
☐ Neurological Disorder		

Social History:

Cigarettes: ________________ packs/day for ________________years. Date Quit?________________

Alcoholic drinks: ________________ drinks per day. Date Quit?________________

Drug Use: ____

Coffee: ________________ cups/day; pop/tea: ________________ glasses/day

Exercise type: ____ Days/week:______________

Hobbies: ____

Birth:	Name of Children	Age
# of pregnancies: ________________		
# of miscarriages: ________________		
# of c/sections: ________________		
# of vaginal: ________________		

Peripheral Arterial Disease (PAD):

☐ Leg Pain while Walking ☐ Leg Muscle Discomfort ☐ Calf Pain
☐ Leg Numbness or Weakness ☐ Cold Feet or Legs ☐ Sores on Toes
☐ Feet or Leg Sores that Will Not Heal

(continued on back)

Review of Systems: (check if you have or have had any of the following)

General
- ☐ Recent Weight Loss or Gain (Please Circle One)
- ☐ Fevers or Nights Sweats (Please Circle One)
- ☐ Mood Disturbance (i.e. Depression, Anxiety, etc.)
- ☐ Fatigue
- ☐ Last Tetanus Shot: ______________
- ☐ Last Flu Shot: ______________

Head/Neurologic
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Paralysis or Weakness of Limbs (Please Circle One)
- ☐ Numbness
- ☐ Tremor or Shakes
- ☐ Poor Coordination
- ☐ Difficulty in Speech
- ☐ History of Head Injury

Ent
- ☐ Seeing Double
- ☐ Dark Spots
- ☐ Flashing Lights Before Your Eyes
- ☐ Recent Change in Eyesight
- ☐ Cataracts
- ☐ Hearing Loss
- ☐ Ringing in the Ears
- ☐ Nose Bleed
- ☐ Hay Fever or Nasal Congestion (Please Circle One)
- ☐ Sinus Infection
- ☐ Sores in Mouth
- ☐ Frequent Sore Throats
- ☐ Difficulty Swallowing
- ☐ Hoarseness or Voice Change (Please Circle One)

Neck
- ☐ Pain or Stiffness in the Neck (Please Circle One)
- ☐ Fullness in the Neck or Throat

Heart And Lungs
- ☐ Heart Attack
- ☐ Angina or Chest Pain
- ☐ Congestive Heart Failure
- ☐ Difficulty Breathing
- ☐ Emphysema or Chronic Bronchitis
- ☐ Asthma or Wheezing
- ☐ Cough
- ☐ Irregular or Rapid Heart Beat
- ☐ Swelling (Edema)
- ☐ Murmurs
- ☐ Mitral Valve Prolapse

Skin/Hair
- ☐ Rashes
- ☐ Sores
- ☐ Lumps
- ☐ Skin Cancers
- ☐ Hair Loss
- ☐ Itching

Stomach And Bowels
- ☐ Nausea/Vomiting
- ☐ Indigestion, Belching, or Excess Gas
- ☐ Food Intolerance
- ☐ Bloating or Abdominal Distension
- ☐ Abdominal Pain
- ☐ Jaundice or Yellow Discoloration
- ☐ Diarrhea or Constipation
- ☐ Bloody or Black Stools

Genitourinary
- ☐ Increased Frequency of Urination
- ☐ Urinary Urgency
- ☐ Getting Up at Night to Urinate:# of Times________
- ☐ History of Urinary Infections
- ☐ Blood in the Urine
- ☐ Difficulty Urinating or Burning or Urination
- ☐ Leakage of Dribbling of Urine
- ☐ History of Venereal Disease
- ☐ Lumps in Genital Area
- ☐ Kidney Stones
- ☐ Prostate Problems
- ☐ Sexual Difficulties

Menstrual
- ☐ Interval Between Menstrual Periods
- ☐ Duration of Flow
- ☐ Any Chance of Pregnancy at This Time
- ☐ Vaginal Discharge
- ☐ Vaginal or Pelvic Discomfort
- ☐ Pain During Intercourse
- ☐ Date of Last Menstrual Period
- ☐ Date of Last Pap
- ☐ Method of Birth Control
- ☐ Mammogram Date:_________________________

Muscles, Bones, And Joints
- ☐ Joint Pain or Stiffness
- ☐ Joint Swelling or Redness
- ☐ Backache
- ☐ Muscle Aches
- ☐ Decreased Muscle Strength

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Physician Signature Date