Medical History and Present Medical Condition Questionnaire

Name: ________________________________ Date: ________________________

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all YES answers at the end of this questionnaire.

PERSONAL MEDICAL HISTORY

Have you have ever had any of the following conditions?

YES	NO		YES	NO		YES	NO	
☐	☐	1. Allergies	☐	☐	11. Ulcer	☐	☐	22. Epilepsy
☐	☐	2. Loss of hearing	☐	☐	12. Heart attack	☐	☐	23. Convulsions/seizures
☐	☐	3. Asthma	☐	☐	13. Heart murmur	☐	☐	24. Stroke
☐	☐	4. Kidney disease	☐	☐	14. Positive stress test	☐	☐	25. Diabetes
☐	☐	5. Prostatitis	☐	☐	15. Heart valve abnormality	☐	☐	26. Thyroid trouble
☐	☐	6. Colitis	☐	☐	16. Angina	☐	☐	27. Anemia
☐	☐	7. Hepatitis	☐	☐	17. Heart failure	☐	☐	28. Eczema
☐	☐	8. Liver disease	☐	☐	18. High cholesterol	☐	☐	29. Cancer (including skin cancer)
☐	☐	9. Elevated liver enzyme test	☐	☐	19. High blood pressure	☐	☐	30. Sleep apnea
☐	☐	10. Pancreatitis	☐	☐	20. Arthritis/rheumatism			
			☐	☐	21. Loss of consciousness			

REVIEW OF CONDITIONS

Do you currently have or have you recently had any of the following?

EYES, EARS, NOSE, THROAT			PULMONARY			GENITO-URINARY		
YES	NO		YES	NO		YES	NO	
☐	☐	31 Difficulty with night vision	☐	☐	40. Shortness of breath	☐	☐	45. Bladder trouble
☐	☐	32. Change in vision	☐	☐	41. Chronic or frequent cough	☐	☐	46. Blood in urine
☐	☐	33. Blurred or double vision	☐	☐	42. Brown/blood-tinged sputum	☐	☐	47. Irregular vaginal bleeding
☐	☐	34. Bleeding gums	☐	☐	43. Chest tightness	☐	☐	48. Currently pregnant
☐	☐	35. Frequent nosebleeds	☐	☐	44. Wheezing	☐	☐	49. Difficulty starting/stopping urination
☐	☐	36. Frequent sinus trouble				☐	☐	50. Urinating 3 times per night
☐	☐	37. Recent hoarseness				☐	☐	51. Frequent or painful urination
☐	☐	38. Ringing/buzzing ears				☐	☐	52. Problems with sexual function
☐	☐	39. Earaches						

GASTROINTESTINAL			CENTRAL NERVOUS SYSTEM			HEART/VASCULAR		
YES	NO		YES	NO		YES	NO	
☐	☐	53. Vomited blood	☐	☐	63. Fainting spells	☐	☐	71. Palpitation (irregular heartbeat)
☐	☐	54. Persistent diarrhea	☐	☐	64. Recurrent dizziness	☐	☐	72. Pain or discomfort in chest
☐	☐	55. Persistent constipation	☐	☐	65. Frequent headaches	☐	☐	73. High cholesterol
☐	☐	56. Frequent abdominal pain	☐	☐	66. Tremors	☐	☐	74. Swelling of feet
☐	☐	57. Frequent nausea	☐	☐	67. Memory loss	☐	☐	75. Leg pain while walking
☐	☐	58. Frequent indigestion/heartburn	☐	☐	68. Loss of coordination	☐	☐	76. Painful varicose veins
☐	☐	59. Black/bloody bowel movement	☐	☐	69. Difficulty concentrating			
☐	☐	60. Hemorrhoids	☐	☐	70. Numbness/tingling extremities			
☐	☐	61. Trouble swallowing						
☐	☐	62. Hernia						

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PERSONAL MEDICAL HISTORY

MUSCULOSKELETAL			MISCELLANEOUS					
YES	NO		YES	NO		YES	NO	
☐	☐	77. Back trouble/pain	☐	☐	81. Bleeding/bruising easily	☐	☐	86. Night sweats
☐	☐	78. Neck trouble/pain	☐	☐	82. Enlarged glands	☐	☐	87. Undesired weight loss
☐	☐	79. Joint injury/pain/swelling	☐	☐	83. Rashes	☐	☐	88. Snoring
☐	☐	80. Carpal tunnel syndrome	☐	☐	84. Unexplained lumps	☐	☐	89. Difficulty sleeping
			☐	☐	85. Chronic fatigue	☐	☐	90. Low blood sugar

ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS

Please answer the following questions honestly:

YES NO

☐ ☐ 91. Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?

☐ ☐ 92. Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage, and the reason the medication is used on the next page.

☐ ☐ 93. Have you had any surgical operations in the last 10 years?

☐ ☐ 94. Has anyone in your immediate family developed heart disease before the age of 60?

☐ ☐ 95. Do any diseases run in your family?

☐ ☐ 96. Do you currently have a cold/cough, or have you had any in the last two weeks?

☐ ☐ 97. Have you ever been hospitalized? If yes, list date, length of stay, and reason on the next page.

☐ ☐ 98. Are you currently under a doctor's care? If yes, list what you are being treated for on the next page.

☐ ☐ 100. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?

☐ ☐ 101. Do you have any special concerns regarding your health that you would like to discuss with the doctor?

☐ ☐ 102. Are you a current cigarette smoker?
A. How many packs of cigarettes do you smoke a day? ____________
B. How long have you been smoking? ____________

☐ ☐ 103. Are you an ex-smoker?
A. How many years did you smoke? ____________
B. How many packs a day? ____________
C. When did you quit? ____________

☐ ☐ 104. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

105. I drink ____________ beers; ____________ ounces of hard liquor; ______ ounces of wine per week.

106. When were your most recent immunizations?

Tetanus ____________ Flu shot ____________ Pneumovax ____________

107. When were you most recent health maintenance screening tests?

Cholesterol ____________ Results? ____________ PSA (Prostate) ____________ Results? ____________

Mammogram ____________ Results? ____________ Sigmoidoscopy ____________ Results? ____________

Pap smear ____________ Results? ____________

108. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

____

____

109. Please describe typical weekly exercise or physical activities including any exercise at work:

____

110. My current diet could be best characterized as (check all that apply):

☐ Low-fat ☐ Low-carb ☐ High-protein ☐ Vegetarian/Vegan ☐ No special diet

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Please explain all YES answers here. List the question number, and add details.

PERSONAL MEDICAL HISTORY

QUESTION NUMBER	DETAILS

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