Medical History Questionnaire

Participant Name _____ Age: _____
first *middle* *last*

CONDITIONS: Check YES or NO column as applicable.

Condition	Yes	No	Description/ Comment	Start Date	Ong	Res. Date
Head Problems				/ /	☐	/ /
Ear problems				/ /	☐	/ /
Nose problems				/ /	☐	/ /
Eye Problems				/ /	☐	/ /
Throat Problems				/ /	☐	/ /
Heart Trouble				/ /	☐	/ /
High Blood Pressure				/ /	☐	/ /
High Cholesterol				/ /	☐	/ /
Asthma/Bronchitis				/ /	☐	/ /
Other Breathing Problems				/ /	☐	/ /
Diabetes				/ /	☐	/ /
Thyroid Disease/Goiter				/ /	☐	/ /
Liver/Gallbladder Problems				/ /	☐	/ /
Ulcer (stomach/duodenum)				/ /	☐	/ /
Other Stomach/Bowel Prob.				/ /	☐	/ /
Kidney/Bladder Problems				/ /	☐	/ /
Prostate Problems				/ /	☐	/ /
Breast Problems				/ /	☐	/ /
Uterine/Ovarian/Cervical				/ /	☐	/ /
Epilepsy, Seizures				/ /	☐	/ /
Stroke or Nerve Problems				/ /	☐	/ /
Other Neurological problems				/ /	☐	/ /
Arthritis/Rheumatism				/ /	☐	/ /
Other Musculoskeletal problems				/ /	☐	/ /
Skin Problems				/ /	☐	/ /
Psychological Problems				/ /	☐	/ /
Anemia/Blood Disease				/ /	☐	/ /
Cancer or Tumors			Record cancer on corresponding condition line.			
Other				/ /	☐	/ /
				/ /	☐	/ /
Other				/ /	☐	/ /
				/ /	☐	/ /

SURGERIES/HOSPITALIZATIONS (✓ 'S' if surgery, or 'H' if hospitalization): List all including childbirth ☐ None

S	H		Date	Reason
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

ALLERGIES: List all including environment, food, dyes & medications: ☐ None

Allergy	Reaction	Date
		/ /
		/ /
		/ /

MEDICATIONS: What over-the-counter, herbal remedies or prescription medication do you take? ☐ None

Medication	Dose	# times/ day	Reason	Start date	Cont ✓	Stop date
				/ /	☐	/ /
				/ /	☐	/ /
				/ /	☐	/ /
				/ /	☐	/ /
				/ /	☐	/ /
				/ /	☐	/ /

SOCIAL HISTORY

Tobacco	Alcohol	Caffeine
☐ Never Used ☐ Ex-user ☐ Currently use	☐ Never Used ☐ Ex-user ☐ Currently use	☐ Never Used ☐ Ex-user ☐ Currently use
Start Date___/___/___ Stop Date ___/___/___	Start Date___/___/___ Stop Date ___/___/___	Start Date___/___/___ Stop Date ___/___/___
# cig. Pks/day _____ # cigars/day _____ # pipefuls/day _____ # pinches/day _____	Beer: # cans/week _____ Wine: # glasses/week ____ Liquor: # drinks/week ____	# oz/day _____

Drug Use : ☐Never Used ☐Ex-user

1. Have you used illicit or recreational drugs in the past 12 months? ☐ No ☐ Yes - If yes, date used:___/___/___
2. Have you ever been in drug/alcohol rehab? ☐No ☐Yes – Date ___/___/___

FOR WOMEN ONLY: Please complete either **Section A** or **Section B.** Date of last menstrual period:___/___/___

Section A - ☐ **Able to have children (childbearing potential). Check primary birth control method used.**

	Oral Contraceptive Pill		Condoms and foam/gel		Vaginal Condom
	Contraceptive Injection		Diaphragm and foam/gel		IUD
	Contraceptive Implant (Norplant)		Condoms only		None
	Partner had vasectomy		Abstinence		Other, type:
	Rhythm		Withdrawal		

Section B – ☐ **Non-childbearing by means of (check one and specify date):**

	Hysterectomy	Date: / /
	Tubal Ligation (tubes tied)	Date: / /
	Bilateral Oophorectomy	Date: / /
	Natural Post-Menopause	Date of last natural menstrual period : / /

Participant Signature_____ **Date**_____

Staff Signature_____ **Date** _____