

## MEDICAL HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ DATE: \_\_\_\_\_

Please answer all questions by circling YES or NO. If necessary, write additional information in the "COMMENTS" section.

<p>1. HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE A HEART, CIRCULATION OR BLOOD PROBLEM?      YES NO</p> <p>A. HEART MURMUR      YES NO</p> <p>B. MITRAL VALVE PROLAPSE      YES NO</p> <p>C. HEART ATTACK: DATE _____ YES NO</p> <p>D. IRREGULAR HEART BEAT      YES NO</p> <p>E. HIGH/LOW BLOOD PRESSURE      YES NO</p> <p>F. STROKE OR BLOOD CLOTS      YES NO</p> <p>G. ANEMIA/SICKLE CELL      YES NO</p> <p>H. ANGINA/CHEST PAIN      YES NO</p> <p>I. BLEEDING PROBLEM      YES NO</p> <p>J. OTHER HEART PROBLEMS      YES NO</p> <p>K. SWOLLEN LEGS/ANKLES      YES NO</p> <p>L. SLEEP ON 3 OR MORE PILLOWS      YES NO</p> <p>2. DO YOU HAVE OR EVER HAD ANY LUNG OR BREATHING PROBLEMS?      YES NO</p> <p>A. ASTHMA      YES NO</p> <p>B. BRONCHITIS      YES NO</p> <p>C. PNEUMONIA      YES NO</p> <p>D. TUBERCULOSIS      YES NO</p> <p>E. CHRONIC LUNG DISEASE      YES NO</p> <p>F. COUGH FREQUENTLY</p> <p>    YES, COUGH UP ANYTHING?      YES NO</p> <p>G. DO YOU SMOKE?      YES NO</p> <p>    HOW MUCH PER DAY? _____</p> <p>    # OF YEARS SMOKED? _____</p> <p>H. ABNORMAL CHEST X-RAY      YES NO</p> <p>I. SHORTNESS OF BREATH      YES NO</p> <p>    1. AT REST      YES NO</p> <p>    2. CLIMBING STAIRS      YES NO</p> <p>    3. WALKING BRISKLY      YES NO</p> <p>3. HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE DIGESTIVE OR STOMACH/LIVER PROBLEMS?      YES NO</p> <p>A. DIFFICULTY SWALLOWING      YES NO</p> <p>B. HIATAL HERNIA      YES NO</p> <p>C. GALL BLADDER DISEASE      YES NO</p> <p>D. JAUNDICE (YELLOW SKIN)      YES NO</p> <p>E. ULCERS      YES NO</p> <p>F. HEPATITIS      YES NO</p> <p>G. DIARRHEA/CONSTIPATION      YES NO</p> <p>H. WEIGHT LOSS IN LAST 4 MONTHS WITHOUT DIETING      YES NO</p> <p>I. EAT ANY SPECIAL DIET      YES NO</p> <p>4. HAVE ANY URINARY, KIDNEY OR BLADDER PROBLEMS?      YES NO</p> <p>A. KIDNEY STONES      YES NO</p> <p>B. FREQUENT INFECTIONS      YES NO</p> <p>C. DIFFICULT OR PAINFUL URINATION      YES NO</p> <p>D. UNABLE TO HOLD URINE      YES NO</p> <p>5. DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:      YES NO</p> <p>A. SEIZURE OR CONVULSION      YES NO</p>	<p>B. HISTORY OF HEADACHES      YES NO</p> <p>C. ARM OR LEG BECOMES WEAK OR NUMB      YES NO</p> <p>6. DO YOU HAVE OR EVER HAD:</p> <p>A. DIABETES: IF YES, ARE YOU: DIET CONTROL _____ INSULIN CONTROL _____</p> <p>B. HYPOGLEMIC (LOW SUGAR)      YES NO</p> <p>C. THYROID PROBLEMS      YES NO</p> <p>7. DO YOU HAVE OR EVER HAD:</p> <p>A. PHYSICAL LIMITATIONS OR USE OF AIDES - (WALKER, WHEELCHAIR, ETC.)      YES NO</p> <p>B. ARTHRITIS      YES NO</p> <p>C. DIFFICULTY WALKING OR LYING FLAT      YES NO</p> <p>D. BACK PROBLEMS      YES NO</p> <p>E. DIFFICULTY HEARING OR DIFFICULTY SPEAKING      YES NO</p> <p>8. ANY MAJOR MEDICAL ILLNESSES? YES NO DESCRIBE _____</p> <p>9. ANY VISION PROBLEMS?      YES NO</p> <p>A. GLASSES      YES NO</p> <p>B. CONTACT LENSES      YES NO</p> <p>10. DENTURES, CHIPPED TEETH, BRACES, BRIDGEWORK, PLATES, LOOSE TEETH (CIRCLE ITEM)      YES NO</p> <p>11. ARE YOU CURRENTLY UNDER THE CARE OF A PSYCHIATRIST/PSYCHOLOGIST?      YES NO</p> <p>12. FOR WOMEN ONLY: IS THERE A POSSIBILITY THAT YOU ARE PREGNANT?      YES NO</p> <p>    DATE OF LAST MENSTRUAL PERIOD _____</p> <p>13. FOR CHILDREN UNDER 16: ARE IMMUNIZATIONS UP TO DATE?      YES NO</p> <p>14. HAVE YOU EVER HAD A POSITIVE HIV TEST? IF YES, IS THE HIV ACTIVE?      YES NO</p> <p>15. ADVANCE DIRECTIVE</p> <p>    I DO NOT HAVE AN ADVANCE DIRECTIVE.</p> <p>    -- A. I WOULD LIKE INFORMATION ABOUT ADVANCE DIRECTIVES</p> <p>    B. I DECLINE INFORMATION ABOUT ADVANCE DIRECTIVES.</p> <p>    I HAVE AN ADVANCE DIRECTIVE ON FILE.</p> <p>    -- IF SO, WHERE? _____</p> <p>COMMENTS: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>LIST ALL MEDICATIONS YOU NOW TAKE, INCLUDING NON-PRESCRIPTION (OVER THE COUNTER) MEDICATIONS:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">MEDICATION DOSE</td> <td>HOW OFTEN?</td> </tr> <tr> <td>SUPPLEMENTS</td> <td>_____</td> </tr> <tr> <td>HERBS</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table> <p>LIST ANY ALLERGIES YOU MIGHT HAVE TO MEDICATIONS:</p> <p>_____</p> <p>_____</p> <p>ALLERGIES TO: CONTACT ITEMS (FOOD, TAPE, SOAPS, LATEX)</p> <p>_____</p> <p>_____</p> <p>LIST OPERATIONS/SURGERIES      YEAR</p> <table border="0" style="width: 100%;"> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table> <p>ANY COMPLICATIONS FROM SURGERY?</p> <table border="0" style="width: 100%;"> <tr> <td>1. BLEEDING</td> <td>YES NO</td> </tr> <tr> <td>2. INFECTION</td> <td>YES NO</td> </tr> <tr> <td>3. THICK SCAR</td> <td>YES NO</td> </tr> <tr> <td>4. SLOW TO HEAL</td> <td>YES NO</td> </tr> <tr> <td>5. OTHER _____</td> <td>_____</td> </tr> </table> <p><b>ANESTHESIA HISTORY</b></p> <p>HAVE YOU OR A BLOOD RELATIVE EVER HAD A PROBLEM WITH GENERAL OR LOCAL ANESTHESIA?      YES NO</p> <table border="0" style="width: 100%;"> <tr> <td>NAUSEA OR VOMITING</td> <td>YES NO</td> </tr> <tr> <td>DROP/INCREASED BLOOD PRESSURE</td> <td>YES NO</td> </tr> <tr> <td>DIFFICULTY IN "WAKING UP"</td> <td>YES NO</td> </tr> <tr> <td>INCREASED TEMPERATURE</td> <td>YES NO</td> </tr> <tr> <td>DIFFICULTY BREATHING</td> <td>YES NO</td> </tr> </table> <p>PLEASE COMPLETE THE FOLLOWING QUESTIONS</p> <p>1. NAME OF FAMILY PHYSICIAN _____ LOCATION _____</p> <p>2. DO YOU CONSUME ALCOHOL      YES NO</p> <p>    HOW MUCH PER DAY _____</p> <p>3. DO YOU HAVE HISTORY OF CANCER?      YES NO</p> <p>    IF YES, SITE: _____</p> <p>    DATE _____</p> <p>4. FAMILY HISTORY OF CANCER      YES NO</p> <p>    IF YES, SITE: _____</p> <p>    RELATIONSHIP _____</p> <p>5. WOULD YOU DESCRIBE YOURSELF AS EXTREMELY ANXIOUS IF CONSIDERING SURGERY?      YES NO</p>	MEDICATION DOSE	HOW OFTEN?	SUPPLEMENTS	_____	HERBS	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	1. BLEEDING	YES NO	2. INFECTION	YES NO	3. THICK SCAR	YES NO	4. SLOW TO HEAL	YES NO	5. OTHER _____	_____	NAUSEA OR VOMITING	YES NO	DROP/INCREASED BLOOD PRESSURE	YES NO	DIFFICULTY IN "WAKING UP"	YES NO	INCREASED TEMPERATURE	YES NO	DIFFICULTY BREATHING	YES NO
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My signature to the right certifies that this information is correct to the best of my knowledge.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
STAFF SIGNATURE