

INTERNAL MEDICINE  
**MEDICAL HISTORY QUESTIONNAIRE**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed      If married, how long? \_\_\_\_\_

# of children \_\_\_\_\_ # of grandchildren \_\_\_\_\_

Do you drink alcohol? .....  YES  NO      If yes, how much? \_\_\_\_\_

Do you smoke? .....  YES  NO      If yes, how much? \_\_\_\_\_

Have you ever smoked? .....  YES  NO      If yes, how long/much? \_\_\_\_\_

Have you ever had a problem with alcohol?      YES  NO

Have you ever had a problem with drugs?      YES  NO

**FAMILY HISTORY:**

Medical Problems/Cause of Death

Father .....  Good  Poor  Deceased \_\_\_\_\_

Mother .....  Good  Poor  Deceased \_\_\_\_\_

Brothers/Sisters.....  Good  Poor  Deceased \_\_\_\_\_

*Please check if any blood relative has had any of the following:*

- |  |                                      |   |  |  |
|--|--------------------------------------|---|--|--|
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Ulcers      | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Liver Problems            |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Cancer-If yes, type: _____ | <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Depression/Mental Illness |
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Anemia      |   | <input type="checkbox"/> Stroke              |  |
| <input type="checkbox"/> Colitis           | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> High Blood Pressure |  |

**PAST MEDICAL HISTORY:**

List hospitalizations/surgeries and year

\_\_\_\_\_ Year: \_\_\_\_\_  
\_\_\_\_\_ Year: \_\_\_\_\_  
\_\_\_\_\_ Year: \_\_\_\_\_  
\_\_\_\_\_ Year: \_\_\_\_\_  
\_\_\_\_\_ Year: \_\_\_\_\_

*Please check if you have had any of the following:*

- |  |                                      |   |  |  |
|--|--------------------------------------|---|--|--|
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Ulcers      | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Liver Problems            |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Cancer-If yes, type: _____ | <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Depression/Mental Illness |
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Anemia      |   | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Colitis           | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> High Blood Pressure |  |

**CURRENT SYMPTOMS:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

**CURRENT MEDICATIONS:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

**Please check if you have or have had within the past year:**

- |  |  |
|--|--|
| <input type="checkbox"/> Tiredness without apparent reason | <input type="checkbox"/> Tingling/weakness of hands/feet     |
| <input type="checkbox"/> Frequent headaches                | <input type="checkbox"/> Changing moles                      |
| <input type="checkbox"/> Fainting spells                   | <input type="checkbox"/> Shortness of breath with exertion   |
| <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Palpitations or fluttering of heart |
| <input type="checkbox"/> Visual Problems                   | <input type="checkbox"/> Swelling of legs                    |
| <input type="checkbox"/> Earaches                          | <input type="checkbox"/> Leg cramps on walking or at night   |
| <input type="checkbox"/> Hearing problems                  | <input type="checkbox"/> Abdominal pain                      |
| <input type="checkbox"/> Sinus problems                    | <input type="checkbox"/> Frequent heartburn                  |
| <input type="checkbox"/> Persistent hoarseness             | <input type="checkbox"/> Loss of appetite                    |
| <input type="checkbox"/> Difficulty swallowing             | <input type="checkbox"/> Nausea or vomiting                  |
| <input type="checkbox"/> Enlarged glands                   | <input type="checkbox"/> Bloody or black bowel movements     |
| <input type="checkbox"/> Sores in mouth                    | <input type="checkbox"/> Pain with urination                 |
| <input type="checkbox"/> Bleeding of gums                  | <input type="checkbox"/> Difficulty starting urination       |
| <input type="checkbox"/> Chest pains                       | <input type="checkbox"/> Getting up at night to urinate      |
| <input type="checkbox"/> Coughed up blood                  | <input type="checkbox"/> Lose urine on coughing/sneezing     |
| <input type="checkbox"/> Night sweats                      | <input type="checkbox"/> Back pains                          |
| <input type="checkbox"/> Chronic cough                     | <input type="checkbox"/> Joint pains                         |
| <input type="checkbox"/> Wake up short of breath           | <input type="checkbox"/> Easy bruising                       |
| <input type="checkbox"/> Swelling of joints                | <input type="checkbox"/> Muscle spasms                       |
| <input type="checkbox"/> Tremors of arms/legs              | <input type="checkbox"/> Skin rashes                         |

**MENSTRUAL HISTORY (women only)**

Age of onset \_\_\_\_\_ Regular?  YES  NO Cycle \_\_\_\_\_ days Vaginal discharge  YES  NO

Date of last pelvic exam \_\_\_\_\_ Are you currently using any contraception?  YES  NO If yes, what form? \_\_\_\_\_