MEDICAL HISTORY QUESTIONNAIRE

**NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SEX** \_\_\_\_\_M \_\_\_\_\_F

**FEMAIES:** LMP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Deliveries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contraception \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pregnant Currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually Active ☐Yes ☐No Nursing Currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History** (Check all that apply)

☐High Blood Pressure ☐Cancer ☐Fainting or Dizzy Spells

☐Frequent Skin Infections ☐Heart Disease ☐Hepatitis

☐Bleeding Disorder ☐Stroke ☐HIV or AIDS

☐Anxiety or Depression ☐Asthma ☐Diabetes

☐Arthritis ☐Seizures ☐Autoimmune Disease

☐Difficult Skin Healing ☐ Abnormal Scars ☐Thyroid Disease

☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History** ( indicate surgeries, approximate year and any complications)

SURGERY YEAR COMPLICATIONS

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**Do you take any of the following medications?**

☐Aspirin/Other anti-inflammatories ☐Arthritis medications

☐Cancer Treatment (chemotherapy) ☐ Prednisone

☐Blood thinners (anti-coagulants) ☐ Pain medication

☐Oral contraceptive or hormone Treatment ☐Fish oil/other supplements

☐Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies/Sensitivities** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Symptoms**

☐Muscle pain ☐Joint pain/swelling ☐Back or neck problems

☐Calf pain with walking ☐Shortness of breath ☐Lymph node enlargement

☐Chest pain ☐Bowel problems ☐Easy bruising

**Lifestyle**

Exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco ☐yes ☐no If yes, number of cigarettes per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol ☐yes ☐no If yes, number of drinks per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_