ArnotHealth

Outpatient Medical Clinic
Medical History Questionnaire

Patients Name: _____ SS# (optional) _____ DOB _____ Age _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: ❑ Single ❑ Widowed ❑ Divorced ❑ Married (Spouse's Name_____)

Notify in Case of Emergency: _____
Name Relationship

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name of your Previous Provider: (if applicable)

PLEASE LIST YOUR MEDICATION(S) BELOW

Name	Strength	Instructions	Name	Strength	Instructions
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

Family History

	Age	Major Medical Problems
Father		
Mother		
Brother(s)		
1		
2		
3		
Sister(s)		
1		
2		
3		
Grandmother - Paternal		
Grandfather - Paternal		
Grandmother - Maternal		
Grandfather - Maternal		
Child(ren)		
1		
2		
3		
4		

Social History and Personal Habits

Please complete to the best of your ability.

1. Stress Level 1 2 3 4 5 6 7 8 9 10
low high
2. Occupation _____
3. Health Hazards at Work _____
4. Hours of Work per Week _____
5. Special Diet _____
6. Normal Weight _____
7. Exercise Routine _____
8. Hours of Sleep per Night _____
9. Do you take any Sleeping Pills ❑ Yes ❑ No
10. Vitamins ❑ Yes ❑ No Type: _____
11. Caffeine ❑ Yes ❑ No Type: _____
Average per Day
12. Do you consume Alcohol? ❑ Yes _____ Avg/Day ❑ No
13. Tobacco Use
❑ Never ❑ Quit (_____year/) ❑ Yes
Type: _____
❑ Cigarettes ❑ Chew ❑ Cigars ❑ Pipes
❑ Other _____
On Average, How much do you smoke? _____
Do you wish to quit? ❑ Yes ❑ No
Are you exposed to second-hand smoke?
❑ Yes ❑ No
14. Recreational Drugs ❑ Yes ❑ No
Specify: _____
15. Have you traveled out of the country in the last 30 days?
❑ Yes ❑ No

Past Medical History

Patient's Name: _____ Patient's DOB: _____

Ear		Nose		Digestive		Skin		Psychological/Emotional	
❑	Dizziness (Vertigo)	❑	Sinus Infections	❑	Hiatal Hernia	❑	Eczema	❑	Depression
❑	Hearing Aids	❑	Sleep Apnea	❑	Heartburn	❑	Melanoma	❑	Anxiety
❑	Past Ear Surgery	❑	Other:	❑	Acid Reflux	❑	Hives	❑	Bipolar Disorder
❑	Other:	**Musculoskeletal**		❑	Ulcers	❑	Skin Cancer	❑	Recent Stress
Cardiac		❑	Arthritis	❑	Irritable Bowel		Location?	❑	Nervous Breakdown
❑	Angina	❑	Osteoporosis	❑	Colitis	❑	Other:	❑	Alcoholism
❑	CHF	❑	Other:	❑	Diverticulitis	**Neurologic**		❑	Suicide Attempt
❑	Heart Attack			❑	Liver Disease	❑	Seizures	❑	Other:
❑	High Blood Pressure	**Endocrine**		❑	Colon Polyps	❑	Epilipesy	**Infectious Disease**	
❑	Pacemaker/ ICD	❑	Diabetes	❑	Other:	❑	Multiple Sclerosis	❑	Syphilis
❑	Heart Valve Disease	❑	Low Thyroid	**Throat**		❑	Stroke/CVA	❑	Hepatitis A/B/C
❑	Rheumatic Fever	❑	High Thyroid	❑	Tonsillitis	❑	Migraine	❑	TB
❑	Irregular Heart Beat	❑	Breast Discharge	❑	Neck Mass	❑	Other:	❑	Measles
❑	Heart Murmur	❑	Other:	❑	Head/Neck Cancer	**Urinary**		❑	Mumps
❑	Other:	**Blood/Immune System**		❑	Dentures	❑	Kidney Disease	❑	Chicken Pox
		❑	Blood Clots	❑	Other:	❑	Kidney Stones	❑	Mononucleosis
Eyes		❑	DVT/PE	**Pulmonary**		❑	UTI's	❑	Immunosuppressive Illness
❑	Glaucoma	❑	Anemia	❑	Emphysema	❑	Other:	❑	Other:
❑	Cataract	❑	Cancer	❑	Asthma	Additional Notes:			
❑	Other:	❑	Lupus	❑	Pneumonia				
		❑	Other:	❑	Frequent Bronchitis				
				❑	Other:				

Females Only

		Dates/Specifics			Dates/Specifics
❑	Age Menses Began		❑	Pregnancies	
❑	Age Menopause		❑	Live Births	
❑	Irregular Menses		❑	Still Births	
❑	Last Mammogram		❑	Miscarriages	
❑	Last Pap Smear		❑	Abortion	
❑	Abnormal Pap Smear		❑	Cesarean Section	
❑	Colonoscopy		❑	Living Children	

Males Only

		Dates/Specifics
❑	Colonoscopy	
❑	PSA	
❑	Rectal Exam	

Immunizations

						Surgeries
❑	Measles	Date Given:	❑	Flu Vaccine	Date Given:	1.
❑	Mumps	Date Given:	❑	DPT	Date Given:	2.
❑	Rubella	Date Given:	❑	Hepatitis A	Date Given:	3.
❑	Tetanus	Date Given:	❑	Hepatits B	Date Given:	4.
❑	Pneumovac	Date Given:	❑		Date Given:	5.
						6.

Hospitalizations

Have you been Hospitalized in the last 5 years? ❑ Yes (Which Hospital? _____) ❑ No

1.	5.
2.	6.
3.	7
4.	8.

I _____(please print name), certify that I have reviewed the above information and it is accurate and complete to the best of my knowledge.

Patient/Guardian Signature:	***Date***