Medical Questionnaire-Maryland Heights Family & Acute Care

Name______________________________ Date________________
Phone (H)______________(C)____________ Occupation________________ Student: FT PT

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING-PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) EPILEPSY	6) THYROID	11) OSTEOPOROSIS	16) ALCOHOLISM	________
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) CANCER	________
3) MENTAL ILL.	8) ASTHMA	13) HEART DISEASE	18)________	________
4) GLAUCOMA	9)ANEMIA	14) STROKE	19)________	________
5) DIABETES	10) BLEEDS EASILY	15) HYPERTENSION		

Hospital Admissions (not including pregnancies)

Year	Illness or Operation	Year	Illness or Operation

LIST ALL MEDICATIONS YOU ARE NOW TAKING	ALLERGIES	VACCINE	TEST/EXAM
		TETANUS/Td	RECTAL/STOOL
		FLU	CHOLESTEROL
		PNEUMONIA	EYE
		HEPATITIS	
		TUBERCULOS	

MEDICAL HISTORY: Mark (C) for current problems. Check (if) and indicate age when you had any of the following symptoms or diseases.

MAIN PROBLEMS 1)________________ 2)________________ 3)________________

__Decreased Hearing
__Ringing in Ear
__Ear Infections-frequent
__Dizzy Spells
__Failing Vision/Eye Pain
__Double or Blurred Vision
__Eye Infections-frequent
__Nose Bleeds-recurrent
__Sinus Trouble
__Sore Throats-frequent
__Hay fever/Allergies
__Hoarseness-prolonged
__Pneumonia/Pleurisy
__Bronchitis/Chronic Cough
__Asthma/Wheezing
__Shortness of Breath
__on Exertion__Lying Flat
__Chest Pain

__High Blood Pressure
__Heart Murmur
__Irregular Pulse
__Palpitations
__Swollen Ankles
__Fainting Spells
__Leg Pain-walking

__Loss of Appetite-Recent
__Difficulty Swallowing
__Indigestion or Heartburn
__Persistent Nausea/Vomiting
__Peptic Ulcers
__Abdominal Pain-chronic
__Gall Bladder Trouble
__Jaundice/Hepatitis
__Change in Bowel Habits
__Diarrhea/Constipation
__Diverticulitis/Crohn's/Colitis
__Blood or Tarry Stools
__Hemorrhoids
__Hernia
__Urine Infections-frequent
__Blood in Urine
__Urination__Overnight > than twice__Painful___Loss of Control
__Decrease in Force/Flow
__Kidney Stones
__Venereal Disease
__Urethral Discharge
__Chronic Fatigue
__Weight Loss-recent
__Anemia__Bruise Easily

__Cancer
__Diabetes
__Thyroid Disease
__Convulsions/Seizures
__Stroke
__Tremor/Hands Shaking
__Muscle Weakness
__Numbness/Tingling Sensations
__Headaches-frequent
__Arthritis/Rheumatism
__Back Pain-recurrent
__Bone Fracture/Joint Injury
__Gout __Osteoporosis
__Foot Pain
__Cold Numb Feet
__Rashes__Hives
__Psoriasis__Eczema
__Sleeping-difficulty
__Nervousness
__Depression
__Memory Loss
__Moodiness-excessive
__Phobias
__Mental Illness
__Varicose Veins/Phlebitis

__Chicken Pox__Polio__Mumps
__Measles__German Measles__Rheumatic Fever
__Scarlet Fever__Tuberculosis__Herpes
__Contact with Blood or Body Fluids

__Alcohol__________oz per week
__Smoking_______cig. Per day _____#yrs
__Coffee/Tea________cups per day

FEMALES-Please Complete
Menstrual Flow:
__Reg __Irreg __Pain/Cramps
Days of Flow_____Length of Cycle
Date - 1st day of last period
____
__Pain/Bleeding during or after sex
Number of:
Pregnancies___Abortions___
Miscarriages___Live Births___
Birth Control Method______________
B.C. Pill (name)______________
__Flushing/Menopause
Date of last PAP Test______________
___Normal ___Abnormal
Date of last Mammogram
___Normal ___Abnormal

Please explain all "yes" answers.

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