

MEDICAL HISTORY QUESTIONNAIRE

Please answer all the questions on both sides of this form. If you are using the form off our FPMC web site be sure to fill out 2 pages. Be assured that all information will remain confidential as part of your medical record.

Name (Patient) _____ DOB ___ / ___ / ___ SS# _____

Guarantor's Name (Statement to be mailed to) _____

Address _____ City _____ State _____ Zip _____

Phone _____ Driver License # _____

Email _____ Race/Ethnic Background _____

Language Preference _____

Name of Employer _____ Phone _____

Names of Dependents _____

What is your *main medical problem* now and *how long* have you had it? _____

What *Medicines* are you taking at this time? Please remember that aspirin or other painkillers, laxatives, vitamins, birth control pills, eye drops, iron or tonics are also medicine and should be listed.

Have you ever had a *reaction or allergy* to any medicine, food or other substances? If yes, what?

Have you ever experienced itching or hives after contact with rubber (latex) products (balloons, rubber gloves, Band Aids, rubber toys, clothing, condoms, or diaphragms) _____

Please list previous *operations*. (Give year done, city and surgeon) _____

Any serious *injury or broken bones*? _____

Any other *hospitalizations*? _____

Do you use tobacco now? _____ In the past? _____ If yes, type, daily amount and how long?

Do you use alcoholic beverages? _____ If yes, type _____ Weekly Amount _____

Please circle the diseases against which you have been immunized: Pneumonia Influenza

Tetanus (indicate year) _____ Hepatitis B _____

When and where have you traveled outside the U.S. or Canada? _____

Have you ever worked in a place where you were around sprays, dust, fumes or excessive noise? _____
Explain. _____

What kind of work have you done most of your life? _____

What is your occupation now? _____

Have you ever had any Radium or X-ray therapy? (If yes, give area of body treated) _____

Were you born with any abnormalities? (If yes, what?) _____

ILLNESSES: Check the () if you've had any of the following.

ILLNESSES: Check the () if a close blood relative/spouse has had any of the following. Indicate on the _____ line, the relationship to the person.

- () Alcoholism
- () Anemia
- () Arthritis
- () Asthma
- () Bleeds Easily
- () Blood Transfusion
- () Diabetes
- () Drug Abuse
- () Eczema, Hives, Rashes
- () Liver Disease, Jaundice
- () Hepatitis
- () Lung Disease
- () Epilepsy, Seizures
- () Glaucoma
- () Heart Disease
- () Kidney Disease or bladder problem

- () Suicide Attempt
- () Eye Problems
- () Phlebitis, Varicose Veins
- () Thyroid Disease
- () Cancer, Tumor
- () High Blood Pressure
- () Ulcer in Stomach or Duodenum

- () Stroke
- () Nervous Breakdown
- () Mumps, Measles, Chicken Pox

- () Rubella, German Measles
- () Rheumatic Fever
- () Osteoporosis
- () Other _____

- () Alcoholism _____
- () Anemia _____
- () Arthritis _____
- () Asthma _____
- () Bleeds Easily _____
- () Blood Transfusion _____
- () Diabetes _____
- () Drug Abuse _____
- () Eczema, Hives, Rashes _____
- () Liver Disease, Jaundice _____
- () Hepatitis _____
- () Lung Disease _____
- () Epilepsy, Seizures _____
- () Glaucoma _____
- () Heart Disease _____
- () Kidney Disease or Bladder Problems _____

- () Suicide Attempt _____
- () Eye Problems _____
- () Phlebitis, Varicose Veins _____
- () Thyroid Disease _____
- () Cancer, Tumor _____
- () High Blood Pressure _____
- () Ulcer in Stomach Or Duodenum _____

- () Stroke _____
- () Nervous Breakdown _____
- () Mumps, Measles, Chicken Pox _____

- () Rubella, German Measles _____
- () Rheumatic Fever _____
- () Osteoporosis _____
- () Other _____

Comments:
