Medical History and Present Medical Condition Questionnaire

Name: _____ Date: _____

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all YES answers at the end of this questionnaire.

PERSONAL MEDICAL HISTORY

Have you have ever had any of the following conditions?

YES	NO		YES	NO		YES	NO	
☐	☐	1. Allergies	☐	☐	11. Ulcer	☐	☐	22. Epilepsy
☐	☐	2. Loss of hearing	☐	☐	12. Heart attack	☐	☐	23. Convulsions/seizures
☐	☐	3. Asthma	☐	☐	13. Heart murmur	☐	☐	24. Stroke
☐	☐	4. Kidney disease	☐	☐	14. Positive stress test	☐	☐	25. Diabetes
☐	☐	5. Prostatitis	☐	☐	15. Heart valve abnormality	☐	☐	26. Thyroid trouble
☐	☐	6. Colitis	☐	☐	16. Angina	☐	☐	27. Anemia
☐	☐	7. Hepatitis	☐	☐	17. Heart failure	☐	☐	28. Eczema
☐	☐	8. Liver disease	☐	☐	18. High cholesterol	☐	☐	29. Cancer (including skin cancer)
☐	☐	9. Elevated liver enzyme test	☐	☐	19. High blood pressure	☐	☐	30. Sleep apnea
☐	☐	10. Pancreatitis	☐	☐	20. Arthritis/rheumatism			
			☐	☐	21. Loss of consciousness			

REVIEW OF CONDITIONS

Do you currently have or have you recently had any of the following?

EYES, EARS, NOSE, THROAT

YES	NO	
☐	☐	31 Difficulty with night vision
☐	☐	32. Change in vision
☐	☐	33. Blurred or double vision
☐	☐	34. Bleeding gums
☐	☐	35. Frequent nosebleeds
☐	☐	36. Frequent sinus trouble
☐	☐	37. Recent hoarseness
☐	☐	38. Ringing/buzzing ears
☐	☐	39. Earaches

PULMONARY

YES	NO	
☐	☐	40. Shortness of breath
☐	☐	41. Chronic or frequent cough
☐	☐	42. Brown/blood-tinged sputum
☐	☐	43. Chest tightness
☐	☐	44. Wheezing

GENITO-URINARY

YES	NO	
☐	☐	45. Bladder trouble
☐	☐	46. Blood in urine
☐	☐	47. Irregular vaginal bleeding
☐	☐	48. Currently pregnant
☐	☐	49. Difficulty starting/stopping urination
☐	☐	50. Urinating 3 times per night
☐	☐	51. Frequent or painful urination
☐	☐	52. Problems with sexual function

GASTROINTESTINAL

YES	NO	
☐	☐	53. Vomited blood
☐	☐	54. Persistent diarrhea
☐	☐	55. Persistent constipation
☐	☐	56. Frequent abdominal pain
☐	☐	57. Frequent nausea
☐	☐	58. Frequent indigestion/heartburn
☐	☐	59. Black/bloody bowel movement
☐	☐	60. Hemorrhoids
☐	☐	61. Trouble swallowing
☐	☐	62. Hernia

CENTRAL NERVOUS SYSTEM

YES	NO	
☐	☐	63. Fainting spells
☐	☐	64. Recurrent dizziness
☐	☐	65. Frequent headaches
☐	☐	66. Tremors
☐	☐	67. Memory loss
☐	☐	68. Loss of coordination
☐	☐	69. Difficulty concentrating
☐	☐	70. Numbness/tingling extremities

HEART/VASCULAR

YES	NO	
☐	☐	71. Palpitation (irregular heartbeat)
☐	☐	72. Pain or discomfort in chest
☐	☐	73. High cholesterol
☐	☐	74. Swelling of feet
☐	☐	75. Leg pain while walking
☐	☐	76. Painful varicose veins

PERSONAL MEDICAL HISTORY

MUSCULOSKELETAL		MISCELLANEOUS			
YES	NO	YES	NO	YES	NO
☐	☐ 77. Back trouble/pain	☐	☐ 81. Bleeding/bruising easily	☐	☐ 86. Night sweats
☐	☐ 78. Neck trouble/pain	☐	☐ 82. Enlarged glands	☐	☐ 87. Undesired weight loss
☐	☐ 79. Joint injury/pain/swelling	☐	☐ 83. Rashes	☐	☐ 88. Snoring
☐	☐ 80. Carpal tunnel syndrome	☐	☐ 84. Unexplained lumps	☐	☐ 89. Difficulty sleeping
		☐	☐ 85. Chronic fatigue	☐	☐ 90. Low blood sugar

ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS

Please answer the following questions honestly:

YES	NO	
☐	☐	91. Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
☐	☐	92. Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage, and the reason the medication is used on the next page.
☐	☐	93. Have you had any surgical operations in the last 10 years?
☐	☐	94. Has anyone in your immediate family developed heart disease before the age of 60?
☐	☐	95. Do any diseases run in your family?
☐	☐	96. Do you currently have a cold/cough, or have you had any in the last two weeks?
☐	☐	97. Have you ever been hospitalized? If yes, list date, length of stay, and reason on the next page.
☐	☐	98. Are you currently under a doctor's care? If yes, list what you are being treated for on the next page.
☐	☐	100. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?
☐	☐	101. Do you have any special concerns regarding your health that you would like to discuss with the doctor?
☐	☐	102. Are you a current cigarette smoker? A. How many packs of cigarettes do you smoke a day? _____ B. How long have you been smoking? _____
☐	☐	103. Are you an ex-smoker? A. How many years did you smoke? _____ B. How many packs a day? _____ C. When did you quit? _____
☐	☐	104. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

105. I drink _____ beers; _____ ounces of hard liquor; _____ ounces of wine per week.

106. When were your most recent immunizations?

Tetanus _____ Flu shot _____ Pneumovax _____

107. When were you most recent health maintenance screening tests?

Cholesterol _____ Results? _____ PSA (Prostate) _____ Results? _____

Mammogram _____ Results? _____ Sigmoidoscopy _____ Results? _____

Pap smear _____ Results? _____

108. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

_____

_____

109. Please describe typical weekly exercise or physical activities including any exercise at work:

_____

110. My current diet could be best characterized as (check all that apply):

☐ Low-fat ☐ Low-carb ☐ High-protein ☐ Vegetarian/Vegan ☐ No special diet

Please explain all YES answers here. List the question number, and add details.

PERSONAL MEDICAL HISTORY

QUESTION NUMBER	DETAILS