

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

E-mail: _____ Home Phone: _____ Mobile Phone: _____

Date of Birth: _____ Height: _____ Weight: _____ Date of Last Menstrual Period: _____ N/A

Reason for Exam: _____

Do you have Asthma? Y N Are you allergic to: X-ray Dye? Y N MRI Dye? Y N Latex? Y N

Food or Drug Allergies? Y N If yes, describe: _____

Do you have Diabetes? Y N Do you have Kidney Disease? Y N Number of alcoholic drinks per week? _____

Smoking History (please check one box):

Never Smoked Former Smoker When did you quit? _____

Current Smoker How many years have you smoked? _____ How many packs per day do you usually smoke? _____

Do you have or have or have you had cancer? Y N If yes, what type of cancer? _____

Have you had chemotherapy? Y N Radiation Therapy? Y N If yes, when? _____

Surgical History (please list surgeries and dates):

Appendix _____ Brain _____ Gallbladder _____

Ovaries _____ Pacemaker _____ Sinus _____

Spine _____ Uterus _____ Other _____

Previous Studies (please list when and where you had the study):

CT Scan Y N _____

Mammogram Y N _____

MRI Scan Y N _____

Nuclear/PET Scan Y N _____

Ultrasound Y N _____

X-Rays Y N _____

Describe Health Conditions You May Have (please describe any known abnormalities or symptoms)

Circulation (heart, high blood pressure, aneurysm, etc) Y N _____

Digestive (esophagus, stomach, bowels, etc) Y N _____

GYN (ovaries, uterus, etc) Y N _____

Nervous System (seizure, stroke, hearing, vision, etc) Y N _____

Respiratory (breathing, emphysema, lungs, etc) Y N _____

Spine/Back (herniated disk, etc) Y N _____

Skeletal System (joints, arthritis, etc) Y N _____

Urinary (kidney, kidney stones, bladder, etc) Y N _____

Other conditions/symptoms Y N _____

Are you in pain? Y N Rate your pain on 1-10 scale, where 10 is the worst pain: _____

Current Medications (please list prescription and non-prescription medications)

