



MEDICAL HISTORY QUESTIONNAIRE

Last Name First Name Middle Initial Date of Birth Today's Date

HEIGHT/WEIGHT

What are your height and weight? _____ ft. _____ in. _____ pounds

MEDICATIONS

Please list any medications you are currently taking: If you have a list, please give it to the nurse.

OPERATIONS

Have you ever had surgery? No Yes

If yes, please list operations

ALLERGIES

Are you allergic to any medication? No Yes

If yes, please list

LIFESTYLE

Do you smoke? No Yes

Cigarettes per day? _____ How many years? _____

Do you drink alcoholic beverages? No Yes

If yes, how much daily? _____

History of Drug abuse? No Yes

PERSONAL HISTORY

Heart problems? No Yes

(Angina, heart attach, chest pain, murmur, valve disease)

Hypertension? No Yes

(High blood pressure)

High cholesterol? No Yes

Lung problems? No Yes

(Emphysema, TB*, asthma, pneumonia)

Liver disease? No Yes

Kidney disease? No Yes

Ulcers/Gastritis? No Yes

Hiatal Hernia? No Yes

History of stroke? No Yes

History of seizures No Yes

Anemia/Sickle Cell No Yes

Bleeding problems No Yes

History of drug abuse? No Yes

Recent cold? No Yes

Diabetes? No Yes

Thyroid disease? No Yes

FAMILY HEALTH HISTORY

Please indicate if any member of your immediate family (mother, father, sister, brother, grandparent, or child) has ever been treated for any of the following. If yes, please list the relative's relationship to you.

ILLNESS	RELATIONSHIP TO YOU	ILLNESS	RELATIONSHIP
Stroke	_____	Colitis	_____
Seizures	_____	Kidney disease	_____
Emphysema	_____	Arthritis	_____
Asthma	_____	Diabetes	_____
High blood pressure	_____	Thyroid disease	_____
Heart attack	_____	Breast cancer	_____
High cholesterol	_____	Colon cancer	_____
Bleeding tendency	_____	Prostate cancer	_____
Ulcer	_____	Other cancer	_____

PFSH - FOR INTERNAL USE ONLY

DETAILED = Pertinent (1 item from either (1) Past, (2) Family or (3) Special History 99203 / 99214 / 99243

COMPREHENSIVE = Complete (1 item from at least 2 or 3 elements for established patient)

(99204 / 99205 / 99215 / 99244/45 or 1 item from all 3 elements for new patients / consultations)

CONSTITUTIONAL SYMPTOMS

- Good general health lately? No Yes
- Recent weight change? No Yes
- Fever? No Yes
- Fatigue? No Yes
- Headaches? No Yes

EYES

- Eye disease or injury? No Yes
- Wear glasses or contacts? No Yes
- Blurred or double vision? No Yes

EAR/NOSE/THROAT

- Hearing loss or ringing? No Yes
- Chronic sinus problems? No Yes
- Nose bleeds? No Yes
- Sore Throat? No Yes
- Swollen glands in neck? No Yes

CARDIOVASCULAR

- Heart trouble? No Yes
- Chest pain/angina? No Yes
- Palpitation? No Yes
- Heart Murmur? No Yes
- Hypertension? No Yes

RESPIRATORY

- Chronic coughs? No Yes
- Shortness of breath? No Yes
- Asthma? No Yes
- Emphysema? No Yes

GASTROINTESTINAL

- Loss of appetite? No Yes
- Nausea/vomiting? No Yes
- Frequent diarrhea? No Yes
- Constipation? No Yes
- Abdominal pain? No Yes

MUSCULOSKELETAL

- Joint pain? No Yes
- Joint stiffness or swelling? No Yes
- Weakness of muscles? No Yes
- Muscle pain / cramps? No Yes

GENITOURINARY

- Frequent urination? No Yes
- Burning/painful urination? No Yes
- Blood in urine? No Yes
- Hernia? No Yes

INTEGUMENTARY

- Rash or itching? No Yes
- Change in skin color? No Yes
- Change in hair or nails? No Yes

NEUROLOGICAL

- Frequent headaches? No Yes
- Light headed/dizzy? No Yes
- Numbness/tingling? No Yes
- Seizures/tremors? No Yes
- Paralysis? No Yes

PSYCHIATRIC

- Memory loss/confusion? No Yes
- Nervousness? No Yes
- Depression? No Yes
- Insomnia? No Yes

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EXPANDED. PROBLEM FOCUSED = Problem pertinent – 99202 / 99213 / 99242 (1 System) – Chief complaint / Recent Occurrence

DETAILED = 2-9 Systems 99203 / 99214 / 99243 – Chief complaint evolved over time

COMPREHENSIVE = 10+ Systems

Patient/Parent Signature _____ Date _____

Physician Signature _____ Date _____