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.

Patient Name _____ DOB ____/___/_____

How did you hear about FPMC? _____

Preferred Pharmacy _____

Past Medical History (PMH) and Family History (FH) (Please check if you or a family member has a history of the following):

PMH	FH	Disease	PMH	FH	Disease
€	€	Alcoholism	€	€	HSV/Cold Sores
€	€	Anemia	€	€	HIV Aids
€	€	Anxiety	€	€	High Blood Pressure
€	€	Arthritis	€	€	High Cholesterol
€	€	Asthma	€	€	Joint Replacement
€	€	Atrial Fibrillation	€	€	Kidney or Bladder Disease
€	€	Autoimmune Disease	€	€	Leukemia
€	€	Bleeds Easily	€	€	Liver Disease, jaundice
€	€	Blood Transfusion	€	€	Lung Disease
€	€	Bone Marrow Transplant	€	€	Lung Cancer
€	€	Breast Cancer	€	€	Lymphoma
€	€	Colon Cancer	€	€	Mumps, Measles, Chickenpox
€	€	COPD	€	€	Phlebitis, Varicose Veins
€	€	Depression	€	€	Radiation Treatment
€	€	Diabetes	€	€	Rheumatic Fever
€	€	Drug Abuse	€	€	Rubella, German Measles
€	€	Eczema, Hives, Rashes	€	€	Seizures, epilepsy
€	€	Eye Problems	€	€	Suicide Attempt
€	€	GERD or reflux	€	€	Stroke
€	€	Glaucoma	€	€	Thyroid Disease
€	€	Hearing loss	€	€	Ulcer (stomach or duodenum)
€	€	Heart Disease	€	€	Other _____
€	€	Hepatitis			

Previous Procedures, Surgeries, and Hospitalizations

Procedure/Surgery/Hospitalization	Date	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Immunizations (Enter date of last immunization)

Flu _____ Hepatitis B _____
Tetanus _____ Pneumococcal _____
Other _____

Social History

Occupation: _____

Employer: _____

Have you ever worked in a place where you were around sprays, dust, fumes or excessive noise?
€ Yes € No If so, please explain _____

Have you traveled internationally?
€ Yes € No If so, where? _____

Do you have an Advanced Directive or a Living Will? € Yes € No _____

Do you currently use tobacco € Yes € No If yes, type and frequency _____
Were you a former tobacco user € Yes € No If yes, type of tobacco used _____
Do you use alcohol? € Yes € No

Medications (prescription, over the counter, supplements, herbals)

Name	Dose	Route	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication or Other Medical Allergies (check all that apply)

€ Latex € Adhesives € Lidocaine or numbing medication

€ I have allergies to the following medications (please list):
_____
_____
_____

Symptoms today _____

Is there anything else in your history that we should be aware of?
_____
_____

_____ _____
Signature of Patient or Guardian Date