Jefferson™ University Physicians

Medical History Questionnaire

Provider you are seeing today: _____

Patient's Name: _____ Date of Birth: _____ Date: _____

Why are you here today? _____

Who referred you? _____

Past Medical History:

Do you have or ever had any of the following conditions? Please check all that apply:

- ☐ Acne
- ☐ Acute Myocardial Infarction (Heart Attack)
- ☐ Anemia (Low Blood Count)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder (Lupus/Scleroderma)
- ☐ Benign Polyps of The Large Intestine (Colon Polyps)
- ☐ Benign Prostatic Hypertrophy (Enlarged Prostate)
- ☐ Blood Transfusion Complications
- ☐ Breast Cancer
- ☐ Cancer
- ☐ Chemotherapy Administration
- ☐ Chest Pain (Angina)
- ☐ Chronic Liver Disease
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Diverticulosis
- ☐ Dizziness
- ☐ Easy Bruising Tendency
- ☐ Edema
- ☐ Emotional Disturbance
- ☐ Factor VII Deficiency (Hemophilia)
- ☐ Fainting (Syncope)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Gastric Ulcer
- ☐ Headache
- ☐ Heart Disease
- ☐ Heartburn
- ☐ Hepatic Disease (Liver Disease)
- ☐ Hepatitis
- ☐ HIV Infection
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Infection of Kidney
- ☐ Irritable Bowel Syndrome
- ☐ Loss of Hearing
- ☐ Lower Back Pain
- ☐ Mitral Valve Disorder
- ☐ Murmurs
- ☐ Nephrolithiasis (Kidney Stones)
- ☐ Obesity
- ☐ Obstructive Sleep Apnea
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pain During Urination
- ☐ Pain When Defecating (Bowel Movement)
- ☐ Peripheral Vascular Disease (Poor Circulation Hands and Feet)
- ☐ Pneumonia
- ☐ Prostate Cancer
- ☐ Prostate Enlargement
- ☐ Pulmonary Disease (Lung Disease)
- ☐ Recent Methicillin-resistant Staff (MRSA)
- ☐ Red Blood in Bowel Movement
- ☐ Rheumatic Fever
- ☐ Rubella
- ☐ Seizure Disorder
- ☐ Sinusitis
- ☐ Stroke Syndrome
- ☐ Taking Aspirin
- ☐ Thromboembolic Disease (Blood Clot Disorder)
- ☐ Thrombophlebitis
- ☐ Thyroid Disorder
- ☐ Transient Ischemic Attack (Mini Stroke)
- ☐ Transient Limb Paralysis
- ☐ Tuberculosis
- ☐ Vaginitis
- ☐ Varicose Veins
- ☐ Vision Problems
- ☐ Other:

_____

_____

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_____

☐ **No Past Medical History**

Hospitalization:

Hospitalization	Date	Reason for Hospitalization

Surgery:

Surgery	Date	Reason for Surgery

☐ **No Surgical or Hospitalization History**

Family History:

Please check all that apply:

	Indicate Family Member
☐ Alzheimer's Disease	
☐ Anemia	
☐ Benign Polyps of The Large Intestine (Colon Polyps)	
☐ Bladder Cancer	
☐ Breast Cancer	
☐ Cancer	
☐ Cervical Cancer	
☐ Chronic Bronchitis	
☐ Chronic Obstructive Pulmonary Disease	
☐ Colon Cancer	
☐ Diabetes Mellitus	
☐ Emphysema	
☐ Family Health Status of Father - Deceased	Age: _____ Cause: _____
☐ Family Health Status of Mother - Deceased	Age: _____ Cause: _____

	Indicate Family Member
☐ FH-Unattainable-Patient Adopted	
☐ Heart Disease	
☐ Hepatic Disorder	
☐ Hypercholesterolemia	
☐ Hypertension	
☐ Osteoporosis	
☐ Ovarian Cancer	
☐ Prostate Cancer	
☐ Pulmonary Disease	
☐ Renal Disease	
☐ Sickle Cell Anemia	
☐ Stroke Syndrome	
☐ Tay-Sachs Disease	
☐ Thromboembolic Disease (Blood Clot Disorder)	
☐ Uterine Cancer	
☐ Other: _____	
☐ Other: _____	
☐ Other: _____	

☐ **No Family Medical History**

Social History:

Marital Status:

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Life Partner

Children's Ages: _____

Please check all that apply:

☐ Alcohol Use — Alcohol Use/Week _____

☐ Drug Use (Recreational) — Explain: _____

_____

_____

☐ Using Intravenous Drugs — Explain: _____

_____

_____

☐ Previous History of Smoking — Date Quit _____ — Methods Used to Quit: _____

Packs Per Day _____ _____

Number of Attempts to Quit _____ _____

Years of Smoking _____

☐ No History of Smoking

☐ Smoking a Pipe — Times per day _____ — How many years? _____

☐ Smoking Cigarettes — Packs Per Day _____ — How many years? _____

☐ Wishing to Stop Smoking

☐ Chew Tobacco (Chewing Nicotine-Containing Substances) — Times per day _____ — How many years? _____

☐ Cigars — Number per day _____ — How many years? _____

☐ Exercise Habits — Times per week _____

☐ Exercising Regularly

☐ Being Sedentary (Do not exercise)

☐ Sexually Active

☐ Occupation — List All: _____

_____

_____

☐ Travel (Recently Out of the Country) — Where? _____

_____

Do you have an advanced directive? ☐ Yes ☐ No

Allergies:

Allergy	Reaction

Medications:

Include vitamins, herbal supplements and over the counter medications

Medications	Dosage	Frequency	Reason for Taking

Have you participated in any clinical trials or used experimental drugs? ☐ Yes ☐ No

Explain: _____

_____

Are you pregnant? ☐ Yes ☐ No LMP Date: _____

Is there anything else about your medical history that we should know? _____

_____

Review of Systems:

Do you have the following symptoms? Please indicate Yes or No:

Fever	☐ Yes	☐ No	Abdominal Pain	☐ Yes	☐ No
Recent Wt Loss	☐ Yes	☐ No	Pain on Urination	☐ Yes	☐ No
Feeling Tired	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No
Eyesight Problems	☐ Yes	☐ No	Limb Pain	☐ Yes	☐ No
Loss of Hearing	☐ Yes	☐ No	Skin Lesions	☐ Yes	☐ No
Nasal Discharge	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No	Limb Weakness	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No	Difficulty Walking	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Muscle Weakness	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Easy Bruising	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Seasonal Allergies	☐ Yes	☐ No

Patient Signature _____ Date _____

I certify that I have reviewed the above information with the patient.

Physician Signature _____ Date _____