MEDICAL HISTORY QUESTIONNAIRE

Patient Name_____ Date of Birth _____
Age _____ Sex _____ Height _____ Weight _____
Who referred you for this visit? If not referred, please indicate _____
Why are you visiting the doctor today? _____

Past Medical History: Do you have, or have you had, any of the following: **(PLEASE CIRCLE)**
Diabetes High blood pressure Heart condition Seizure Sleep apnoea Ulcer Cancer Blood or bleeding disorder Phlebitis or blood clots Stroke Asthma Emphysema Complication of anaesthesia (including family history) Kidney stone
List any other medical conditions and/or illnesses not mentioned above _____
_____
List reasons for hospitalisations and/or surgeries with dates and any complications including anaesthesia
_____
List any significant injuries you have sustained and when _____
List current medications _____
List any Allergies e.g. Drugs _____/ Latex Allergy? Yes□ No□

Family History (if deceased, please provide age and cause)
Age(s) and overall health of parents _____
Age(s) and overall health of sibling(s) _____
List any significant family health problems _____

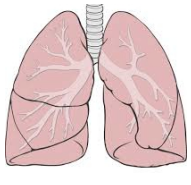
Social History
Marital status _____ Employer _____ Occupation _____
Alcohol use (type/amount) _____ Tobacco use (amount/years used) _____

Review of Systems (Circle positive symptoms and describe and/or add others, if needed.)

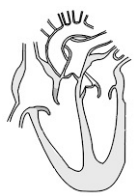
Constitutional: Fever, weight gain/loss, loss of appetite **Eyes:** Double vision, blurring, difficulty seeing **ENT:** Deafness, sinusitis, hoarseness, vertigo **Cardiovascular:** Chest pain, palpitations, irregular/rapid heartbeat, murmur **Respiratory:** Shortness of breath, wheezing, spitting blood, chronic cough **Digestive:** Abdominal pain, constipation, diarrhoea, bleeding **Infections:** History or recent contact with MRSA/VRE	**Urologic:** Pain when urinating, hesitancy, bleeding, incontinence **Skin:** Rashes, lesions that do not heal, changes in moles If female, **Gynaecologic:** Breast masses, pain, discharge, other problems Is there any possibility you could be pregnant? _____ Are you taking any contraceptive pills? _____ Date of first day of last menstrual period _____	**Psychiatric:** Depression, anxiety, hallucinations, sleep disturbances **Endocrine:** Excessive thirst, excessive urination, heat/cold intolerance **Blood and Lymph:** Anaemia, bleeding tendencies, swollen nodes **Allergic and Immunologic:** Hives, eczema, itching **Musculoskeletal:** Stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arm/leg **Neurologic:** Seizures, loss of balance/coordination, paralysis, weakness, loss of memory

Other:_____
Patient Signature_____ Date_____

For Medical Personnel: **Initial Medical Assessment**
The patient's past medical history, family history, social history, and review of systems were reviewed and updated as above and dated_____
Diagnosis _____ Medications: Yes (see Kardex)□ No□
Vitals: See nursing observation sheet □
Examination: _____
_____
_____
Plan & Procedure:_____
_____
Comments:_____
_____
Doctor Signature_____ MCRN_____ Date & Time_____



Clear □



HS I & II □
No murmurs □