ALL AMERICAN FAMILY & GERIATRIC CARE
MEDICAL HISTORY QUESTIONNAIRE

SOCIAL HISTORY

Do you smoke at this time: YES NO

If Yes how many per day: _____ what age did you start: _____

Do you drink alcohol: YES NO If yes how much: _____

Frequency: DAILY WEEKLY SOCIALLY

OCCASIONALLY

Do you exercise: YES NO Type of exercise: _____ Frequency: _____

Do you follow a diet: Low Sugar Low Cholesterol Low Carbohydrate Low Fat

Vegetarian Vegan None

FAMILY HISTORY

Father: Living Deceased Age currently/age at death: _____

Health problems: _ _____ Cause of death: _____

Mother: Living Deceased Age currently/age at death: _____

Health problems: _____ Cause of death: _____

Is there a family history of the following conditions (circle any that apply)

Breast Cancer Colon Cancer Colon polyps Hypertension Drug addiction

Alcoholism Early Heart disease (before age 55) Diabetes

High Cholesterol Thyroid disorders

Any other important family history: _____

_____

_____

_____

_____

_____

(Please circle any of these conditions that pertain to you)

Surgical History

General	**Year**
Aortic aneurysm repair	
Coronary artery	
Bypass surgery	
Aortic valve repair	
Mitral valve replacement	
Pacemaker placement	
Gastric Bypass surgery	
Varicose vein surgery	
Bariatric Surgery	
Removal of parotid	
Septum and nose repair	
Tonsillectomy	
Cataract surgery: Right Left	
Appendix removal	
Gallbladder removal	
Colon resection	
Hemorrhoid removal	
Polyp removal	
Groin hernia repair: Right Left	
Hernia repair: Femoral/Inguinal	
Kidney removal: Right/Left	
Parathyroid removal	
Thyroid tumor removal	
Thyroid removal	
Carpal tunnel release	
Fracture repair: _____	
Spinal surgery: _____	
Mass Excision: Where: _____	

Joint Replacement	**Year**
Left hip	
Right hip	
Left knee	
Right knee	
Left shoulder	
Right shoulder	

Women **Year**

C-section
Colposcopy
D & C
Endometrial biopsy
Hysterectomy:
Partial (ovaries saved) Complete
Ovary removal
Tubal ligation
Breast Implants
Breast Reduction
Lumpectomy: Right breast Left breast
Mastectomy: Right breast Left breast

Men **Year**

Circumcision
Prostate biopsy
Prostate removal
Vasectomy

Any other surgeries that you have undergone that are not listed:

_____
_____
_____

In the past MONTH have you experienced any of the following symptoms?

General

Fatigue
Night Sweats
Weakness
Weight Gain
Weight Loss

Skin

Acne
Dry Skin
Mole Changes
Rash
Skin Injury

Breast (Women)

Lumps
Nipple Discharge

Respiratory

Cough
Discolored Phlegm
Shortness of Breath
Sleep Apnea
Snoring
Wheezing

Reproductive (Women)

Decreased Libido
Bleeding Between Periods
Pain during Intercourse
Postmenopausal Bleeding
Vaginal Discharge/Dryness

Musculoskeletal

Arthritis
Back Pain
Gout
Joint Pain

Head
Tension Headache
Migraines
Head injury

Eyes
Cataracts
Glasses or Contacts
Glaucoma
Use of Eye Drops

Ears/Nose/Throat
Earache
Hearing Aids
Hearing Loss
Ringing in Ears
Hay Fever
Loss of Smell
Nose Bleeds
Runny Nose
Bleeding Gums
Bad Breath
Dry Mouth
Hoarseness
Sore Throat

Neck
Pain
Stiffness
Swollen Glands

Cardiology
Chest Pain
High Blood Pressure
Heart Murmur
Leg Cramps/Swelling

Gastrointestinal
Abdominal Pain
Nausea/Vomiting
Bloating
Constipation/Diarrhea
Difficulty Swallowing
Heartburn
Rectal Pain/Bleeding

Urinary
Abnormal Urine Color/Odor
Blood in Urine
Dribbling
Frequency
Incontinence
Pain during urination

Reproductive (Men)
Decreased Libido
Erectile Dysfunction
Testicular Pain/Swelling

Endocrine
Excessive Hunger
Excessive Sweating
Thyroid problems
Unusual Hair Loss
Change in Ring/Shoe Size

Hematologic
Anemia
Easy Bruising

Lymphatic
Lymph Node Pain
Lymph Node Swelling

Vascular
Blood Clots in Legs
Varicose Veins

Neurological
Abnormal Gait
Clumsiness
Difficulty Concentrating
Difficulty with Speech
Disequilibrium
Dizziness
Memory Loss
Numbness
Seizures
Tingling
Tremors

Psychiatric
Anxiety
Crying
Depression
Insomnia
Panic Attacks

Health Maintenance

Last Physical:_____

Eye Exam: _____

Dental Exam: _____

Colorectal Screening: _____

Men

Prostate Exam: _____

PSA: _____

Women

Pap Smear:_____

Mammogram: _____

Current Medications and Allergies

Are you allergic to any medications: YES NO

If yes please list medications and reactions below:

Medication	Reaction (Describe)

Medications (Include Over the counter and herbs)

(Attach additional List if needed)

Medication Name	**Dosage**	**Times Per Day**

Medical History (please circle any of these conditions that pertain to you)

Common Conditions

Hypertension
Type 1 Diabetes
Type 2 Diabetes
High Cholesterol
Low Thyroid
Coronary Artery Disease
Congestive Heart Failure
COPD
Osteoporosis
Osteoarthritis
Depression
Anxiety

Cancer

Have you ever been
Diagnosed with cancer?
Type: _____

_____

H/E/E/N/T

Acoustic Neuroma
Lazy Eye
Nose Bleeds
Glaucoma
Macular Degeneration
Diabetic Retinopathy

Respiratory

Asthma
Pulmonary Hypertension
Chronic Bronchitis
Lung Disease
Emphysema
Pulmonary Embolism
Obstructive Sleep Apnea
Tuberculosis

Cardiology

Atrial Fibrillation
Pacemaker
Date of placement: _____
Angina
Deep Vein Thrombosis
Heart Attack

Gastrointestinal

Diverticulosis
Hemorrhoids
Inguinal Hernia
Crohn's Disease
Irritable Bowel Syndrome
Barrett's Esophagus
Gastritis
Peptic Ulcer Disease
Ulcerative Colitis

Acid Reflux
Hiatal Hernia
Umbilical Hernia

Urinary/Renal

Kidney Stones

Polycystic Kidney Disease

Kidney Failure

Urinary Incontinence

Urinary Tract Infections

Musculoskeletal

Arthritis

Back Pain

Osteopenia

Carpal Tunnel Syndrome

Restless Legs Syndrome

Rotator Cuff Syndrome

Scoliosis

Sciatica

Spinal

Stenosis:

Lumbar Spine

Cervical Spine

Reproductive (Women)

Cervical Polyps

Endometriosis

Fibrocystic Breast Disease

Ovarian Cyst

Polycystic Ovarian Disease

PMS

Uterine Prolapse

Neurology

Stroke

Alzheimer's Dementia

Vascular Dementia

Gait Instability with falls

Peripheral Neuropathy

Transient Ischemic Attacks

Bell's Palsy

Migraine Headache

Multiple Sclerosis

Neuralgia

Parkinson's Disease

Seizures

Trigeminal Neuralgia

Psychiatric

Alcoholism

Anorexia

ADD/ADHD

Bipolar Disorder

Bulimia

Drug Abuse

Reproductive (Men)

Erectile Dysfunction

BPH

Hypogonadism

Skin

Acne

Eczema

Psoriasis

Rosacea

Rheumatology

Gout

Lupus

Fibromyalgia

Rheumatoid Arthritis

Hematology

B-12 Deficiency Anemia

Iron Deficiency Anemia

Polycythemia Vera

Myelodysplastic Syndrome

Endocrine

Grave's Disease

Hyperparathyroidism

Hyperthyroidism

Obesity

Thyroid Nodule

PATIENT INFORMATION

NAME: _____

(FIRST) (LAST)

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** M F T

SOCIAL SECURITY NUMBER: _____

DRIVERS LICENSE #: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME #: _____ **CELL #:** _____ **EMAIL:** _____

PRIMARY INS: _____

ID#: _____

SECONDARY INS: _____

ID#: _____

HOW DID YOU HEAR ABOUT US:

_____

PHARMACY NAME: _____

PHARMACY #:_____

POWER OF ATTORNEY

NAME: _____ PHONE #: _____

EMERGENCY CONTACT:

NAME: _____ PHONE: _____

RELATIONSHIP: _____

RACE: WHITE AFRICAN AMERICAN HISPANIC ASIAN
OTHER: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PRIMARY LANGUAGE: ENGLISH SPANISH INDIAN KOREAN CHINESE ITALIAN GERMAN OTHER: _____

EMPLOYMENT: RETIRED FULL-TIME PART-TIME UNEMPLOYED SELF EMPLOYED MILITARY

STUDENT: FULL-TIME PART-TIME NOT A STUDENT

PATIENT SIGNATURE: _____

DATE: _____

Reviewed by: _____