



MEDICAL HISTORY QUESTIONNAIRE

1) **WHAT IS YOUR MAIN REASON FOR COMING HERE?** _____

Where and when was this diagnosed? _____

Please select anything that you may need help with below:

Housing in Anchorage Yes No Finances Yes No Care at Home Yes No
 Medical Equipment Yes No Transportation Yes No Emotional Support Yes No

Other (Please Explain) _____

2) **LIST ALL PREVIOUS DOCTORS/PHYSICIANS YOU HAVE SEEN, INCLUDING FIRST NAME, CITY, STATE AND PHONE**

Doctor/Physician	City/State	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) **ALLERGIES TO FOOD OR DRUGS**

Food or Drug	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

4) **MEDICINES USED REGULARLY**

Medication Name	Dosage	Used For:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5) **PLEASE LIST ANY PREVIOUS CANCER TREATMENTS, INCLUDING RADIATION THERAPY**

6) **LIST ALL OTHER PREVIOUS SURGERIES (INCLUDE DATE, REASON AND DOCTOR)**

7) PLEASE LIST ANY PROBLEM(S) YOU MAY HAVE HAD

- Heart attack Arthritis Difficulty urinating Circulation problems
- Seizures/Epilepsy Ulcer Kidney problems Hepatitis/Jaundice at birth
- Gall bladder disease Change in bowel habits Mental health problems Tuberculosis
- Liver disease Cancer Other lung disease Pneumonia
- Stroke Diabetes Chronic bronchitis/Emphysema High blood pressure
- Transfusion Other _____

8) FOR WOMEN – MENSTRUAL HISTORY

Age period began _____ Cycle _____ days Is your cycle regular at this time? Yes No
 Any abnormal discharge or bleeding? Yes No Birth Control or other hormones? Yes No
 Age at menopause _____ How many children? _____ How many pregnancies? _____
 Age at first term delivery _____ Still Births _____ Abortions _____ Did you breast-feed? Yes No

9) SOCIAL HISTORY

Birthplace _____ Do you live alone? Yes No
 Marital Status _____ Name of Spouse _____
 Do you have children? Yes No Ages of Children _____
 Occupation _____ Unemployed? Yes No Retired? Yes No
 Have you had any of the following in the last 2 years?
 Change of Job? Yes No Previous occupation _____
 Change of residence? Yes No Environmental exposures? Yes No
 Loss of spouse, relative or friend? Yes No Do you have interests or hobbies that you pursue with any regularity? Yes No
 If yes, what? _____

 Have you traveled outside the country? Yes No If yes, approximate dates _____

10) HAVE YOU EVER USED TOBACCO? Yes No

Type: Cigar Cigarette Pipe Snuff Chewing Tobacco How much? _____ How often? _____
 Have you quit? Yes No If yes, when did you quit? _____

11) HAVE YOU EVER USED ALCOHOL? Yes No

Are you currently using alcohol? Yes No What kind (beer, wine, hard liquor)? _____
 How much? _____ How Often _____

12) DO YOU USE RECREATIONAL DRUGS OF ANY KIND? Yes No

What Kind? _____ How much? _____ How often? _____

SYSTEMS REVIEW & FAMILY HISTORY

13) ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (PLEASE CHECK ANY THAT APPLY)

- Pain Weakness or numbness in arms or legs Difficulty breathing Nausea or vomiting
 Headaches Change in bowel or bladder habits Depression or mood swings
 Change in vision Forgetfulness or difficulty concentrating Stress symptoms

Has your weight changed recently? Yes No Why? _____

Usual weight _____ Current Weight _____ Do you exercise regularly? Yes No

Are you on a special diet? Yes No Type? _____

Do you have pets? Yes No Type of pet(s) _____

14) CIRCLE OR UNDERLINE ALL THAT APPLY IN THE CHART BELOW:

HEALTH PROBLEM	SELF	FAMILY	NO
Headaches (sinus or migraine), head trauma, spinning sensation.			
Detached retina, cataract, glaucoma, eye injury, crossed eyes, blurred vision, double vision, color blindness, eye infections, or any other disorder of the eye.			
Sinus infections, hearing loss, ear infections, ringing in the ears, frequent sore throat, soreness of the mouth or tongue, voice change, hoarseness.			
Lymph node enlargement in the neck, goiter.			
Breast pain, nipple discharge, breast lumps, implants, fibrocysts.			
Night sweats, cough, yellow or green sputum, pain in the chest when coughing, shortness of breath after being asleep supine, wheezing during exertion or when exposed to cold temperature, shortness of breath during exertion or at rest, inability to walk a city block or more without shortness of breath.			
Chest pain at rest or during exertion, heart murmur, irregular heartbeat, fast or slow heartbeat, ankle swelling, rheumatic fever, shortness of breath when sleeping on less than 2 pillows.			
Ulcers, colitis, appetite increase or decrease, weight loss or weight gain (how much? _____) nausea, vomiting, vomiting blood, bloody stools or black stools, bloody diarrhea or watery diarrhea (how many times per day? _____), difficulty swallowing, abdominal pain or swelling, constipation, hemorrhoids, gallstones, cirrhosis, hepatitis, jaundice.			
Blood in urine, difficulty passing urine, decreased stream, decrease in urine amount, increase in urine amount, painful urination, increased frequency, inability to hold urine, pus in urine, dark urine, increased frequency during the night, bladder infections, kidney stones.			
Heavy periods, irregular periods, painful periods, vaginal discharge, abnormal pap smear, uterine fibroid, enlarged prostate, prostatitis			
Sexually transmitted disease such as genital herpes, syphilis, gonorrhea, chlamydia, venereal warts.			
Fractures, sprains, muscle pain, muscle tenderness or swelling, muscle stiffness, muscle weakness, wasting or cramps, joint swelling or pain, joint stiffness, loss of limb, back or neck pain.			
Skin dryness, scaling, bruising, itching, rash, loss of color in skin or hair, nail changes (brittle, ridging, curvature or loss), hair loss.			
Lymph node enlargement, pain or drainage.			
Heat intolerance, cold intolerance, change of color in fingertips with mild cold (pale, blue, red, numbness), tremor, increased thirst, impotency, sterility.			
Loss or change in sense of smell, hearing or vision, difficulty chewing or swallowing, difficulty with speech, weakness of face, arms or legs, loss of balance or gait difficulties, tingling of face, arms, legs, fingers or toes, loss of equilibrium.			
Seizures, transient loss of vision or strength in leg or arm, transient numbness, stroke, loss of control of bowels or bladder.			
Muscular or neurological disorder such as muscular dystrophy, multiple sclerosis, cerebral palsy or Parkinson's disease.			
Emotional conditions, attempted suicide, depression, mental retardation, eating disorders such as anorexia or bulimia.			
Disease related to the immune system including Acquired Immune Deficiency Syndrome (AIDS), HIV, or AIDS-related Complex (ARC). If HIV positive, please list date of diagnosis:			
Congenital diseases or birth defects.			
Varicose veins, blood clots, painful calves when walking, or any vascular disorder.			

15) PLEASE COMPLETE YOUR FAMILY HISTORY IN THE CHART BELOW

FAMILY MEMBER	ALIVE?	AGE/AGE AT DEATH	LIST ANY HEALTH PROBLEMS
Paternal Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Paternal Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Maternal Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Maternal Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		

FOR NURSE'S USE

B/P _____ PULSE _____ HT _____ WT _____ BSA _____