



Today's Date _____

Patient Name _____

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? _____

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 _____

Revised 11/2011