SLUCare®
Physician Group

MRN #: ___________________

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Family Medicine

Medical History Questionnaire

Patient Name: ______________________________ Date of Birth: ______________

Type of work? ______________________________ Reason for visit? ______________________________

PATIENTS 17 YEARS OF AGE OR YOUNGER:

Biological Mother's Name: ______________________

Mother's address: ______________________________ City: _______________ State: ______ Zip: __________

Mother's cell: ______________________ Mother's home phone: ______________________

Biological Father's Name: ______________________

Father's address: ______________________________ City: _______________ State: ______ Zip: __________

Father's cell: ______________________ Father's home phone: ______________________

Legal Guardian's Name: ______________________

Guardian's address: ______________________________ City: _______________ State: ______ Zip: __________

Guardian's cell: ______________________ Guardian's home phone: ______________________

Immunizations

Have you brought your immunization record today? Yes No

Please check immunizations you have received. List approximate date for each.

☐ Influenze (Flu) _____/_____ ☐ Tetanus _____/_____

☐ Pnemonia (Pneumovax) _____/_____ ☐ Hepatitis B _____/_____ ☐ Shingles (Zostavax) _____/_____

Medical Problems Please circle "Yes" or "No" for each medical condition.

Alcohol/drug use	Yes	No	Cancer	Yes	No	Cataract	Yes	No
Heart murmur	Yes	No	Glaucoma	Yes	No	Anemia	Yes	No
Heart attack	Yes	No	Allergies	Yes	No	Osteoporosis	Yes	No
Circulation problem	Yes	No	Nerve/muscle disease	Yes	No	High blood pressure	Yes	No
Anxiety	Yes	No	Heartburn/GERD/ulcers	Yes	No	Congestive heart failure	Yes	No
Pnemonia	Yes	No	Colitis/bowel disease	Yes	No	Asthma	Yes	No
HIV/AIDS	Yes	No	Arthritis/gout	Yes	No	Stroke	Yes	No
Depression	Yes	No	Sickle cell	Yes	No	Kidney disease	Yes	No
Genetic birth defect	Yes	No	Jaundice	Yes	No	Emphysema/COPD	Yes	No
Thyroid disease	Yes	No	Diabetes	Yes	No	Blood trasnfusion	Yes	No
Meninigitis	Yes	No	Blood clots	Yes	No	Viral hepatitis	Yes	No
Epilepsy/seizures	Yes	No	Tuberculosis	Yes	No	Elevated cholesterol	Yes	No
Atrial fibrillation	Yes	No	Mental Health problem	Yes	No	Other:		
Angina	Yes	No	Carotid artery disorder	Yes	No			

Surgical History Please circle "Yes" or "No" for each and indicate year.

Abdominal surgery	Yes	No	Gallbladder	Yes	No	Breast surgery	Yes	No
Appendectomy	Yes	No	Colon surgery	Yes	No	Broken bones/ fractures	Yes	No
Biopsies	Yes	No	Plastic surgery	Yes	No	Heart bypass	Yes	No
Joint replacement	Yes	No	Brain surgery	Yes	No	Hernia repair	Yes	No
C-section	Yes	No	PTCA/ stent	Yes	No	Hysterectomy	Yes	No
Heart valve	Yes	No	Sterilization	Yes	No	Tonsillectomy	Yes	No

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Social History Circle "Yes" or "No" for each and fill in the blanks.

Do you drink alcohol? Yes No If yes, how many drinks per week? _______

Tobacco Use (check one) ☐ Never smoked ☐ Currently smoke _____cigarettes/packs for _____ years

☐ Used to smoke Year Quit: _____

Are you exposed to passive smoke because family/friends smoke around you? Yes No

Have you ever used drugs? Yes No If yes, type of drugs: ______________________

Are you currently sexually active? Yes No If yes, with: ☐ Men ☐ Women ☐ Both

Do you use birth control? Yes No If yes check all type used:

☐ Condom ☐ Pill ☐ Diaphragm ☐ IUD ☐ Surgical ☐ Spermicide ☐ Implant ☐ Rhythm

☐ Injection ☐ Insert

Do you have a dentist? Yes No If yes, name: ______________________________

Do you have an opthalmologist/optometrist? Yes No If yes, name: ______________________________

Do you see any other specialists? Yes No If yes, whom: ____

____

____

Family History

Check one: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed

Spouse's name: ______________________ Number of Children: _______

Please identify the relationship to each family member who has had any of these medical conditions:

Cancer (type)	______________________	High cholesterol	______________________
Diabetes	______________________	Arthritis	______________________
Heart failure	______________________	Stroke	______________________
Hypertension	______________________	Thyroid disease	______________________
Asthma	______________________	Coronary artery disease	______________________
Seizures	______________________	Rashes	______________________
Migraines	______________________	Other	______________________

Review of Systems Are you currently experiencing and of the following? Please circle "Yes" or "No" for each.

Body			**Eyes**			**Throat**	b		**Intestines**		
Fever	Yes	No	Blurry/ double	Yes	No	Hoarse	Yes	No	Nausea	Yes	No
Chills	Yes	No	vision	Yes	No	Sore	Yes	No	Vomiting	Yes	No
Weight gain or loss	Yes	No	Avoid light	Yes	No	**Head**			Diarrhea	Yes	No
Extra thirsty	Yes	No	Pain	Yes	No	Fainting	Yes	No	Constipation	Yes	No
Skin			Discharge	Yes	No	**Breath**			Pain	Yes	No
Rash	Yes	No	Redness	Yes	No	Shortness of breath	Yes	No	Blood in stool	Yes	No
Itch	Yes	No	**Ears**			Difficulty breathing	Yes	No	Black stools	Yes	No
Dry	Yes	No	Hearing loss	Yes	No	Cough	Yes	No	**Glands**		
Nose			Ringing in ears	Yes	No	Wheezing	Yes	No	Swollen	Yes	No
Bleeding	Yes	No	Pain	Yes	No	**Leg(s)**					
Congested	Yes	No	Discharge	Yes	No	Swelling	Yes	No			

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Review of Systems (Continued)

Urinary			**Mood**			**Muscle/Joint**		
Pain	Yes	No	Tired	Yes	No	Pain	Yes	No
Too often	Yes	No	Nervous	Yes	No	Neck/ back pain	Yes	No
Blood	Yes	No	Depressed	Yes	No	Fall	Yes	No
Chest			**Blood**			**Other**		
Chest pain left	Yes	No	Bruising	Yes	No	____________________		
Chest pain right	Yes	No	Easy bleeding	Yes	No	____________________		
Heartburn	Yes	No				____________________		

Women

Date of last menstrual period: ________ Number of pregnancies: ________

Additional Information Is there any general information about your health, or specific information about your main problem that you feel your physician should know?

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