

**Medical History Intake Questionnaire**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Medical History: Check (x) the box next to any illness that applies to YOU:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Allergies                               | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Respiratory problems     |
| <input type="checkbox"/> Anemia                                  | <input type="checkbox"/> Clotting disorder        | <input type="checkbox"/> Heart attack           | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Anxiety                                 | <input type="checkbox"/> COPD                     | <input type="checkbox"/> Heart murmur           | <input type="checkbox"/> Sick cell                |
| <input type="checkbox"/> Arthritis                               | <input type="checkbox"/> Depression               | <input type="checkbox"/> Hernia                 | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Aspiration<br>(swallowing difficulties) | <input type="checkbox"/> Diabetes mellitus        | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Substance abuse          |
| <input type="checkbox"/> Asthma                                  | <input type="checkbox"/> Diarrhea / constipation  | <input type="checkbox"/> Hyperlipidemia         | <input type="checkbox"/> Thyroid disease          |
| <input type="checkbox"/> Blood transfusion                       | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Meningitis             | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Cancer                                  | <input type="checkbox"/> Falls                    | <input type="checkbox"/> Nerve / muscle disease | <input type="checkbox"/> Vision problem           |
| <input type="checkbox"/> Cataracts                               | <input type="checkbox"/> GERD (reflux)            | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Anesthetic complications |
|  |   | <input type="checkbox"/> Rash/eczema            |   |

Other: \_\_\_\_\_

Surgical History: Check (x) the box next to any surgical procedures YOU have had:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Adenoidectomy    | <input type="checkbox"/> Ear tubes            | <input type="checkbox"/> Joint replacement       | <input type="checkbox"/> Tonsillectomy     |
| <input type="checkbox"/> Appendectomy     | <input type="checkbox"/> Eye surgery          | <input type="checkbox"/> Prostate surgery        | <input type="checkbox"/> Tracheotomy       |
| <input type="checkbox"/> Brain surgery    | <input type="checkbox"/> Fracture surgery     | <input type="checkbox"/> Shunt                   | <input type="checkbox"/> Tubal ligation    |
| <input type="checkbox"/> CABG             | <input type="checkbox"/> G-tube placement     | <input type="checkbox"/> Small intestine surgery | <input type="checkbox"/> Valve replacement |
| <input type="checkbox"/> Colon surgery    | <input type="checkbox"/> Gall bladder Surgery | <input type="checkbox"/> Spine Surgery           | <input type="checkbox"/> Vasectomy         |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Hernia repair        | <input type="checkbox"/> Tongue tie clipped      |  |
| <input type="checkbox"/> C-section        | <input type="checkbox"/> Hysterectomy         |  |  |

Other surgeries: \_\_\_\_\_

Allergies: Check (x) the box next to any allergies YOU have:

- Penicillin  Sulfa  Latex

Other: \_\_\_\_\_

Medications: Please elaborate about any medications YOU are currently taking:

Name of drug:	When started:	Name of drug:	When started:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Pain: For the current condition you are being seen for, rate your pain from 0 (none) to 10 (worst imaginable).**

**Pain now \_\_\_\_\_ ; Worst pain \_\_\_\_\_**

*Do Not File In Medical Record After Discharge*