

The Carrell Clinic

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

Medical Problems: (Either now or in the past.)

	YES	NO
LUNG PROBLEMS		
Bronchitis	()	()
Emphysema	()	()
Pneumonia	()	()
Asthma	()	()
Hayfever	()	()
Other: _____		

HEART PROBLEMS		
Heart Murmur	()	()
Heart Attack	()	()
Heart Failure (CHF)	()	()
Heart Pain (Angina)	()	()
Pace Maker	()	()
Irregular Heartbeat	()	()
Other: _____		

BLOOD PRESSURE		
High	()	()
Low	()	()

DIABETES		
Juvenile type	()	()
Adult onset type	()	()

ARTHRITIS		
Osteoarthritis	()	()
Rheumatoid arthritis	()	()
Osteoporosis	()	()
Gout	()	()
Other: _____		

GI PROBLEMS		
Peptic Ulcer	()	()
Gallbladder Disease	()	()
Colitis	()	()
Hepatitis	()	()
Cirrhosis	()	()
Other: _____		

MALIGNANT HYPERTHERMIA	()	()
REACTION TO ANESTHESIA	()	()

DRUG ALLERGIES **YES** **NO**
 Name: _____

 Reaction: _____

KIDNEY PROBLEMS

Stones	()	()
Infection (Pyelonephritis)	()	()

URINARY PROBLEMS

Infection	()	()
Prostate Disease	()	()

GLAUCOMA	()	()
BLINDNESS	()	()
DEAFNESS	()	()

SPECIAL DIET	()	()
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POSITIVE HIV	()	()
AIDS	()	()
ANEMIA	()	()

SEIZURE DISORDER	()	()
CONCUSSION	()	()

CANCER	()	()
Type: _____		

ORGAN TRANSPLANT	()	()
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STROKE	()	()
BLOOD CLOTS	()	()
CLAUSTROPHOBIA	()	()

THYROID DISEASE	()	()
Specify: _____		

BLOOD TRANSFUSION	()	()
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If hospitalized for any medical condition, (other than surgery admissions), please list:

DATE	REASON	DOCTOR

PAST SURGICAL HISTORY: (Please list all previous surgeries)

DATE	PROCEDURE	SURGEON
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Weight: _____

Height: _____

SOCIAL HISTORY

1. Are you pregnant? _____ Yes _____ No (If yes, please tell us)
2. Marital Status: M S D W (Circle One)
3. If you were to have surgery, would you have someone to assist you at home after discharge?
_____ Yes _____ No
4. Do you Smoke? _____ Yes _____ No Packs per day: _____ Number of years: _____
Use Alcoholic Beverages? _____ Yes _____ No Quantity: _____ (Drinks per day)
5. Do you use any Recreational Drugs?
Please List: _____

6. Occupation: _____ Circle One: Full Time Part Time

FAMILY HISTORY

1. Please list any family medical conditions we should know about: _____

Is there a family history of:	1. Blood Clotting disorders	Yes	No
	2. Malignant Hyperthermia	Yes	No
	3. Reaction to Anesthesia	Yes	No

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms? Circle Y or N for each item. If ALL items are "No", circle here: **ALL NO**

Y N Fever	Y N Unexplained Weight Change	Y N Change in Stool color	
Y N Chills	Y N Productive Cough	Y N Abdominal Pain	
Y N Fatigue	Y N Night Sweats	Y N Burning with Urination	
Y N Skin Rash or Eruption	Y N Shortness of Breath	Y N Blood in Urine	
Y N Frequent/Unusual Headaches	Y N Chest Pain	Y N Loss in Force Of Stream	
Y N Dizziness	Y N Foot/ankle Swelling	Y N Tremors	
Y N Fainting	Y N Bruising/ Bleeding Easily	Y N Depression	
Y N Loss of Vision	Y N Heartburn	Y N Nervousness	
Y N Ringing in the Ears	Y N Nausea	Y N Sleep Disturbances	
Y N Frequent Nosebleeds	Y N Vomiting	Numbness:	
		Y N Right Arm	
		Y N Left Arm	
Y N Tooth Abscess	Y N Constipation	Y N Right Leg	
Y N Heat/Cold Intolerance	Y N Diarrhea	Y N Left Leg	