Physicians Medical Center
Patient History Questionnaire

Name: ___________________________________DOB: ______Age:____ Sex: ____

Occupation: ______________________________ Retired: □ Yes □ No

Marital Status: □ Married □ Single □ Widowed □ Divorced

Living Will: □ Yes □ No **Advance Directive: □ Yes □ No**

Live Alone: □ Yes □ No Automobile License: □ Yes □ No

Med_____________________Dose________Med_________________Dose_______
Med_____________________Dose _______ Med_________________Dose_______
Med_____________________Dose _______ Med_________________Dose_______
Med_____________________Dose _______ Med_________________Dose_______
Vitamins: ____

Smoking: □ Yes □ No Quantity_______ How Long_____ Coffee: □ Yes □ No
Alcohol: □ Yes □ No Quantity ______ Aspirin: □ Yes □ No Quantity_____

Childhood Immunizations: □ Yes □No Adult: Diptheria/Tetnus: Year__________

Flu Shot: Year_____ Pneumonia Shot: Year_____ Hepatitis Vaccine: Year________

Allergies: ____

Childhood Illness: Measles □ Yes □ No Mumps: □ Yes □ No Chicken Pox: □ Yes □ No

Surgeries or Hospitalizations: List Procedure and approximate Year

Adult Medical Problems: (Check all that apply)

Anemia___
Arthritis___
Asthma___
Blood Transfusion___
Cancer___
Diabetes___
HIV___
Gallbladder___
Gout___
Heart Disease___
Hypertension___
High Cholesterol__
Kidney Disease___
Liver Disease___
Lung Disease___
Nervous System Disease___
Pneumonia___
Skin Disease___
Stomach Problems___
Stroke___
Thyroid Disease___

Other Significant Disease:

Family History:
Mother Living: ☐Yes ☐ No   Father Living: ☐ Yes ☐No   Siblings: Number __________

Family Disease History: (Check all that apply)
Cancer___   Diabetes___   Heart Disease___   High Cholesterol__   Hypertension___
Kidney Disease___   Stroke___   Liver Disease___   Thyroid Disease___
Other Significant Family Disease:

Review of Systems: (Check all current symptoms that apply)

General:
Fatigue___
Fever___
Recent weight loss/gain___
Loss of sexual function___
Weakness___

Heart / Lungs:
Chest pain___
Cough___
Heart Mummer___
Irregular Heart beat___
Passing Out___
Shortness of breath___
Swollen legs or feet___
Wheezing___

Kidney/Urine/Bladder:
Blood in urine___
Difficult or burning___
Discharge___
Frequency/Urgency___
Prostate problems___
Vaginal bleeding___
Vaginal dryness___

Muscles/Joints/Bones:
Joint pain___
Joint swelling___
Muscle pain or weakness___

Nervous System:
Dizziness___
Fainting___
Headache___
Memory loss___
Muscle spasm___
Weakness either side___

Stomach:
Black stools___
Heartburn___
Indigestion___
Constipation___
Nausea___
Vomiting blood or dark material___

Nose/Throat:
Bleeding___
Pain___
Difficulty swallowing___

Skin:
Rash___
Lesion___
Itching/ Infection___
Yellow Jaundice

Emotional:
Stress___
Anxiety___
Depression___
Sleep problems___

ScreeningProcedure:
(Last Date if Known)
Blood Work_______
Chest X-ray________
EKG_____________
Mammogram______
Pap Smear_________
Colonoscopy_______
Treadmill__________
TB Test___________

Patient Signature: ___________________________________**Date:**________________