Name:____________________

Date: ______________________

MEDICAL HISTORY QUESTIONNAIRE

Welcome to the office of Drs. Schnall, Devlin, Gupta and Curran. In order that we may get to know you better, please complete this form and bring it with you to your visit.

What brings you to see the doctor?

____

____

____

____

Please list all of your physicians (including the physician who referred you to our office):

____

____

____

____

Please list all medications you are now taking (doses, tablet size, frequency, and approximately how long you have been on each, if possible):

____

____

____

____

Please list any medicines to which you are allergic, as well as the nature of the allergic reaction:

<u>Medicine</u> <u>Reaction</u>

____

____

Are you allergic to intravenous dye (contrast) such as that given with CAT scans?
(circle one) Yes No

Describe your reaction to dye: ____

PAST MEDICAL HISTORY

Please circle and describe below all of the following surgeries which you have had. Write the approximate year of surgery next to any circled answer.

Appendix	Prostate	Tonsils/Adenoids
Gallbladder	Hysterectomy	Oral Surgery
Kidney	Ovaries	Sinus Surgery
Stomach	Breast	Skin
Hernia	Thyroid	Broken Bones
Intestines	Eye/Cataracts	Artificial Joint
Heart	Hemorrhoid	Varicose Veins
Lung	Spine	Cancer Surgery
Neurosurgery (Brain, Spinal Cord)		

Other Surgery:
____
____
____

If you have been previously hospitalized, please complete:

Year	Reason	Hospital
__________	______________________	_______________
__________	______________________	_______________

Please circle and describe below any of the following medical conditions you have had in your lifetime:

High Blood Pressure
Heart Attack
Heart failure
Bronchitis
Asthma
Pleurisy
Tuberculosis
Urine/Bladder Infection
Kidney Trouble
Kidney Stones
Prostate Infection
Venereal Disease
Cancer (Type: ____________)

Hepatitis
Gastrointestinal Disease
Angina
Heart Murmur
Leaky Heart Valve
Rheumatic Fever
Lyme Disease
Seizures
Nervous Disorder
Blood Clots (Phlebitis)
Phlebitis
Glaucoma
HIV

Pneumonia
Emphysema
Hiatal Hernia
Ulcer
Stomach Reflux
Gallstones
Arthritis
Anemia
Blood Transfusion
Diabetes
Thyroid Disease
Blood Disorder
Stroke

Any other illness: ____
____
____

Occupation: ____

Do you smoke? Yes_______ No _________
If yes, how much do you smoke in one day? ____
If no, in the past did you ever smoke regularly? _________________________
How much did you smoke? ___________________ When did you stop? _________________

Do you drink alcohol? Yes ___________ No _______________
If yes, please estimate the amount consumed each day: _________________
If no, did you ever drink alcohol regularly in the past? _____________________

Have you ever been exposed to asbestos? Yes ________ No ________
Where and when? ____

Have you ever used any hormone treatment (such as estrogen, etc.)?
Yes __________ No ________
When? _________________ How long? ___________

Place an (x) alongside any of the following symptoms you have noticed and describe below:

__poor appetite
__weight gain
__weight loss
__fever, chills
__excess sweating
__fatigue
__trouble with vision
__eye pain or redness
__hearing trouble
__ear pain/discharge
__ringing in ears
__nosebleeds
__nasal discomfort
__throat discomfort
__voice change
__dental/gum symptom
__cough
__sputum
__chest pains
__wheezing
__heart “skipping”
__shortness of breath
__pain
__lumps

__swollen feet/ankles
__leg pains
__leg ulcers
__varicose veins
__jaundice
__heartburn
__difficulty swallowing
__special food intolerance
__abdominal pain
__nausea
__vomiting
__vomiting blood
__belching/flatulence
__black stools/rectal bleeding
__rectal discomfort
__diarrhea
__backache
__arthritis/joint pain
__”bursitis”
__muscular aches
__burning on urination
__frequency of urination

__nighttime urination
__urgency of urination
__difficulty starting urination
__loss of control of urine
__pus in urine
__blood in urine
__bruise or bleed easily
__swollen glands
__hot weather intolerance
__cold weather intolerance
__increased thirst
__increased urine volume
__skin problems
__hair/nail problems
__itching
__headaches
__dizziness
__fainting
__numbness, pins/needles
__tremor
__muscle weakness/paralysis
__seizures, convulsions
__faulty memory

__nervousness
__depression
__trouble sleeping
__work/family problems
__sexual problems

MEN:

__weak urine stream
__prostate trouble
__discharge from penis
__painful/swollen testes
Date of last prostate exam_________________
Dr who performed last prostate exam__________
Was it normal? Yes No
Date/value of last PSA
____

WOMEN:

__trouble with menstruation
__vaginal discharges
__hot flashes
__breast lump/discharge
Date of last period _______
Date of last mammogram___
Location of last mammogram
____
Was it normal? Yes No
Date of last Pap test_______
Dr who performed Pap___

Please describe any other symptoms: ____
____
____

Date of last rectal/Hemoccult (test for blood in stool) exam __________ Was it normal? Yes ___ No ____

Doctor who performed rectal/Hemoccult ________________________________

Please fill in your family history:

RELATIVE	AGE IF LIVING	CAUSE OF DEATH IF DECEASED	AGE AT DEATH	MEDICAL PROBLEM
FATHER				
MOTHER				
SIBLINGS				
SPOUSE				
CHILDREN				

Please describe any cancer history in your family (or any other important family history not listed above):

____

____

____

Please include if you have had depression, alcohol, or drug difficulties or unusual anxiety:

____

____

____

An Oncology social worker is available free of charge in our practice for individual/family counseling, coping with your diagnosis, insurance or employment issues, community resources and to work with children whose parents are going through cancer treatment.

___ Please check if you would like to be seen by the social worker.

___ Our practice has access to the latest clinical trials which may pertain to your condition. Please check here if you would be interested in hearing about these clinical trials.

Is there anything else you think we should know?

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