



Medical History and Present Medical Condition Questionnaire

Name: _____ Date: _____

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all YES answers at the end of this questionnaire.

PERSONAL MEDICAL HISTORY

Have you ever had any of the following conditions?

YES	NO	YES	NO	YES	NO
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REVIEW OF CONDITIONS

Do you currently have or have you recently had any of the following?

EYES, EARS, NOSE, THROAT		PULMONARY		GENITO-URINARY	
YES	NO	YES	NO	YES	NO
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GASTROINTESTINAL		CENTRAL NERVOUS SYSTEM		HEART/VASCULAR	
YES	NO	YES	NO	YES	NO
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PERSONAL MEDICAL HISTORY

MUSCULOSKELETAL

YES NO

- 77. Back trouble/pain
- 78. Neck trouble/pain
- 79. Joint injury/pain/swelling
- 80. Carpal tunnel syndrome

MISCELLANEOUS

YES NO

- 81. Bleeding/bruising easily
- 82. Enlarged glands
- 83. Rashes
- 84. Unexplained lumps
- 85. Chronic fatigue

YES NO

- 86. Night sweats
- 87. Undesired weight loss
- 88. Snoring
- 89. Difficulty sleeping
- 90. Low blood sugar

ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS

Please answer the following questions honestly:

YES NO

- 91. Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
- 92. Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage, and the reason the medication is used on the next page.
- 93. Have you had any surgical operations in the last 10 years?
- 94. Has anyone in your immediate family developed heart disease before the age of 60?
- 95. Do any diseases run in your family?
- 96. Do you currently have a cold/cough, or have you had any in the last two weeks?
- 97. Have you ever been hospitalized? If yes, list date, length of stay, and reason on the next page.
- 98. Are you currently under a doctor's care? If yes, list what you are being treated for on the next page.
- 100. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?
- 101. Do you have any special concerns regarding your health that you would like to discuss with the doctor?
- 102. Are you a current cigarette smoker?
 - A. How many packs of cigarettes do you smoke a day? _____
 - B. How long have you been smoking? _____
- 103. Are you an ex-smoker?
 - A. How many years did you smoke? _____
 - B. How many packs a day? _____
 - C. When did you quit? _____
- 104. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

105. I drink _____ beers; _____ ounces of hard liquor; _____ ounces of wine per week.

106. When were your most recent immunizations?

Tetanus _____ Flu shot _____ Pneumovax _____

107. When were you most recent health maintenance screening tests?

Cholesterol _____ Results? _____ PSA (Prostate) _____ Results? _____

Mammogram _____ Results? _____ Sigmoidoscopy _____ Results? _____

Pap smear _____ Results? _____

108. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

109. Please describe typical weekly exercise or physical activities including any exercise at work:

110. My current diet could be best characterized as (check all that apply):

- Low-fat
- Low-carb
- High-protein
- Vegetarian/Vegan
- No special diet

