Behavioral Health and Education Specialists

Medical History Questionnaire

Patient's Name:		**Today's Date:**		
Parent/Guardian's Name (if under 18 years old):		**Patient Date Of Birth:**		
Marital Status:	❑ S ❑ M ❑ D ❑ W	**Height:**	**Weight:**	
Primary Care Physician's Name:		**Primary Care Physician Phone:**		
Date of Last Medical Exam:		**Primary Care Physician Fax:**		

Medical History

1) Do you have any allergies to medications? ❑ Yes ❑ No

2) List all medications you are currently taking (including all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin and diet supplements). Also, list any medications you take on an as-needed basis (such as Viagra, Albuterol, Nitroglycerin, etc):

❑ None ❑ See Below

Medication	Dose	How Often Do You Take The Medication	Name Of Prescriber	Date First Prescribed

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3) List all major injuries, surgeries and/or hospitalizations you have had in your life:

❑ None ❑ See Below

_____

_____

_____

_____

4) Are you pregnant and/or nursing? ❑ Yes ❑ No ❑ N/A

5) Do you wear glasses or contact lenses? ❑ Yes ❑ No

6) List any eye illnesses, diseases or problems you have experienced: ❑ None ❑ See Below

_____

_____

_____

Family Medical History

Do any blood relatives have any of the following medical conditions in their history (parents, grandparents, siblings, children, aunts, uncles, nieces, nephews, cousins; living or deceased) for the following conditions?

Disease/Condition	Yes	No	Unsure	Relationship To You
Arthritis	☐	☐	☐	
Autoimmune Disease	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other	☐	☐	☐	

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Social History

1) Do you drive? ❑ Yes ❑ No ❑ N/A

2) Do you use tobacco products? ❑ No ❑ See Below

Type of Tobacco (e.g., chew, cigarettes, snuff, …)	How Often	How Much	Age Started	Age Stopped

3) Do you drink alcohol products? ❑ No ❑ See Below

Type of Alcohol (e.g., beer, wine, hard liquor…)	How Often	How Much	Age Started	Age Stopped

4) Do you use illegal drugs? ❑ No ❑ See Below

Type of Drug (e.g., cocaine, crack, heroin, marijuana, LSD, mushrooms, ecstasy…)	How Often	How Much	Age Started	Age Stopped

5) I have previouly been exposed to/or infected with: ❑Chlamydia ❑Crabs ❑Gonorrhea

❑ Hepatitis ❑ Herpes ❑ HIV/AIDS ❑ HPV ❑ Syphilis

❑ Other(s):_____

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Review Of Systems (Please mark a selection for each below)

System	No	Yes	Unsure
Allergic/Immunologic			
Allergies	☐	☐	☐
Immune System	☐	☐	☐
Bones, Joints, Muscles			
Arthritis/Joint Pain	☐	☐	☐
Muscle Pain	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Cardiovascular, Vascular			
Aneurysm	☐	☐	☐
Blood Clots	☐	☐	☐
Cholesterol	☐	☐	☐
Diabetes	☐	☐	☐
Heart Attack	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Vascular Disease	☐	☐	☐
Constitutional			
Fever	☐	☐	☐
Weight Gain/Loss	☐	☐	☐
Ear, Mouth, Nose, Throat			
Chronic Cough	☐	☐	☐
Dry Throat or Mouth	☐	☐	☐
Hay Fever, Seasonal Allergy	☐	☐	☐
Nasal Congestion	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Runny Nose	☐	☐	☐
Endocrine			
Thyroid Glands	☐	☐	☐
Eyes			
Blurred/Double Vision	☐	☐	☐
Dryness/Itching	☐	☐	☐
Loss of Vision	☐	☐	☐

System	No	Yes	Unsure
Gastrointestinal			
Acid Reflux	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Genitourinary			
Bladder	☐	☐	☐
Incontinence	☐	☐	☐
Kidney	☐	☐	☐
Urinary Tract Infections	☐	☐	☐
Uterus	☐	☐	☐
Integumentary			
Skin	☐	☐	☐
Hematologic, Lymphatic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Neurological			
Coordination/Dizziness	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Nutritional			
Vitamin B12 Deficiency	☐	☐	☐
Vitamin D Deficiency	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐

If you answered Yes to any of the above or have a condition(s) not listed, please list and note any medications you took to treat the condition(s):

_____

_____

_____ _____

Patient's Signature (Typed Is Acceptable) **Date**