VALLEY MEDICAL PRIMARY CARE

6611 CLYO ROAD, SUITE E, CENTERVILLE OH 45459

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ DOB:_____

Race:_____Caucasian _____African American _____Asian _____Other

CURRENT MEDICATIONS

Please List Current Medication, Dosages, and Frequency:

_____

_____

_____

_____

_____

Please List any Medication Allergies:

_____

_____

_____

_____

PAST SURGICAL HISTORY

List any Surgery and Date:

_____

_____

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FAMILY HISTORY

Please check box of relative with condition.

	Mother	Father	Maternal Grandparents	Paternal Grandparents	Siblings	Children
CORONARY ARTERY DISEASE						
CONGESTIVE HEART FAILURE						
HYPERTENSION						
PVD						
ASTHMA						
COPD						
COLITIS						
LIVER DISEASE						
GLAUCOMA						
ARTHRITIS						
DEGENERATIVE JOINT DISEASE						
ANEMIA						
ALZHEIMER'S DISEASE						
CVA/TIA						
DEMENTIA						
MIGRAINE						
SEIZURES						
ALCOHOLISM						
DRUG ABUSE						
MENTAL ILLNESS						
PSYCHIATRIC ILLNESS						
DIABETES MELLITUS						
THYROID PROBLEMS						
KIDNEY DISEASE						
OSTEOPOROSIS						
ALLERGIES						
CANCER						
HYPERLIPIDEMIA						
HIV/AIDS						

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SOCIAL HISTORY

Circle One Please

Alcohol	Never	Remote use	Quit	Consumes
	Rarely	Moderate	Heavy	
Exercise	No	Yes		
Illicit Drugs	Never	Cocaine	Marijuana	Heroin
	IV drugs		Remote use	Quit
Marital Status	Married	Unmarried	Divorced	Widower / Widow
Sexually Active	No	Yes		
Smoking	Quit	Current non-smoker	Smoker	Non-smoker Ex-smoker
Smoking PPD	_____			
Caffeine	Never	Quit	Consumes	
Drug abuse	No	Yes		
Home smoke detector use	No	Yes		
Pets	No	Yes		
Soda	Never	Quit	Consumes	
Recreational Drugs	Never	Quit	Consumes	
Smoking Duration	_____			
Tobacco	Never chewed tobacco	Remote use	Ex-tobacco chewer	Chews tobacco
Travel Outside US	No	Yes		

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PAST MEDICAL HISTORY

Cardiovascular		
Angina	No	Yes
Atrial fibrillation	No	Yes
Heart attack	No	Yes
Heart failure	No	Yes
Heart murmur	No	Yes
Heartvalve abnormality	No	Yes
Hypertension	No	Yes
PVD	No	Yes
Respiratory		
Asthma	No	Yes
Blood clot in lungs	No	Yes
COPD	No	Yes
Pneumonia	No	Yes
Pneumothorax	No	Yes
Sleep apnea	No	Yes
Gastro		
Colitis	No	Yes
Colon polyps	No	Yes
Elevated liver enzyme test	No	Yes
GERD	No	Yes
Hemorrhoids	No	Yes
Liver cancer	No	Yes
Pancreatitis	No	Yes

Genitourinary		
Prostatitis	No	Yes
HEENT		
Glaucoma	No	Yes
Loss of hearing	No	Yes
Musculoskeletal	No	Yes
Arthritis/Rheumatism	No	Yes
Chronic muscular disease	No	Yes
Fibromyalgia	No	Yes
Hematologic	No	Yes
Anemia	No	Yes
Neurology		
Neurological disease	No	Yes
Convulsions/Seizures	No	Yes
Dementia	No	Yes
Epilepsy	No	Yes
Loss of consciousness	No	Yes
Stroke	No	Yes
Psychiatric		
Anxiety	No	Yes
Depression	No	Yes

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Endocrine		
Diabetes	No	Yes
Diabetes Mellitus	No	Yes
Hyperthyroidism	No	Yes
Hypothyroidism	No	Yes
T. Adenoma	No	Yes
Thyroid trouble	No	Yes
Nephrology		
Kidney disease	No	Yes
Kidney failure	No	Yes
Orthopedics		
Fracture	No	Yes

Skin		
Eczema	No	Yes
Ulcer	No	Yes
Oncology		
Cancer	No	Yes
Metabolic disorders		
High cholesterol	No	Yes
High lipids	No	Yes
Osteoporosis	No	Yes
Infectious diseases		
Hepatitis	No	Yes
Herpes zoster/shingles	No	Yes
HIV	No	Yes

Patient Signature: _____

Date: _____