INTERNAL MEDICINE ASSOCIATES OF TEXAS

Medical Questionnaire

Name _____ Date _____

Past Medical History:

Check (✓) conditions you have or have had in the past.

❒ AIDS	❒ Cataracts	❒ Hepatitis	❒ Migraine Headaches	❒ Stroke
❒ Anemia	❒ Chemical Dependency	❒ Herpes	❒ Multiple Sclerosis	❒ Thyroid Problems
❒ Arthritis	❒ Chicken Pox	❒ High Blood Pressure	❒ Mumps	❒ Tuberculosis
❒ Asthma	❒ Depression	❒ High Cholesterol	❒ Pacemaker	❒ Ulcers
❒ Back Problems	❒ Diabetes	❒ HIV Positive	❒ Pneumonia	❒ Veneral Disease
❒ Blood Transfusion	❒ Emphysema	❒ Kidney Disease	❒ Polio	
❒ Bleeding Disorders	❒ Epilepsy	❒ Kidney Stone	❒ Prostate Problem	
❒ Breast Lump	❒ Glaucoma	❒ Liver Disease	❒ Rheumatic Fever	
❒ Cancer	❒ Heart Disease	❒ Measles	❒ Scarlet Fever	

Past Surgical History: _____

_____

Hospitalization Other Than Surgery: _____

_____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

Allergies to Medications, X-Ray Dyes, or Other Substances ❒ **No** ❒ **Yes**
(If yes, please list name of medicine and type of reaction)

Family History: Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	**Which family member?**	**Age when diagnosed**
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other		

Immunization history — Have you had?

Hepatitis B Vaccine ❒ No ❒ Yes When?_____
Hepatitis A Vaccine ❒ No ❒ Yes When?_____
Pneumovax immunization? ❒ No ❒ Yes When?_____
Tetanus immunization? ❒ No ❒ Yes When?_____

Review of Systems: Check (✓) symptoms you currently have or have had in the past year.

General
- ❒ Chills
- ❒ Depression/Nervousness
- ❒ Dizziness/Fainting
- ❒ Fever
- ❒ Forgetfulness
- ❒ Headache
- ❒ Loss of sleep
- ❒ Loss of weight
- ❒ Numbness
- ❒ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:
- ❒ Arms
- ❒ Back
- ❒ Feet
- ❒ Hands
- ❒ Hips
- ❒ Legs
- ❒ Neck
- ❒ Shoulders

Genito-Urinary
- ❒ Blood in urine
- ❒ Frequent urination
- ❒ Lack of bladder control
- ❒ Painful urination

Gastrointestinal
- ❒ Appetite poor
- ❒ Bloating
- ❒ Bowel changes
- ❒ Constipation
- ❒ Diarrhea
- ❒ Excessive thirst
- ❒ Gas
- ❒ Hemorrhoids
- ❒ Indigestion
- ❒ Nausea
- ❒ Rectal bleeding
- ❒ Stomach pain
- ❒ Vomiting
- ❒ Vomiting blood

Cardiovascular
- ❒ Chest pain
- ❒ High/Low blood pressure
- ❒ Irregular/Rapid heart beat
- ❒ Poor circulation
- ❒ Swelling of ankles
- ❒ Varicose veins

Eye, Ear, Nose, Throat
- ❒ Bleeding gums
- ❒ Blurred vision
- ❒ Crossed eyes
- ❒ Difficulty swallowing
- ❒ Double vision
- ❒ Earache/Ear discharge
- ❒ Hay fever
- ❒ Hoarseness
- ❒ Loss of hearing
- ❒ Nosebleeds
- ❒ Persistent cough
- ❒ Ringing in ears
- ❒ Sinus problems
- ❒ Vision - Flashes/Halos

Skin
- ❒ Bruise easily
- ❒ Hives
- ❒ Itching/Rash
- ❒ Change in moles
- ❒ Scars
- ❒ Sore that won't heal

MEN only
- ❒ Erection difficulties
- ❒ Lump in testicles
- ❒ Penis discharge
- ❒ Sore on penis

Date of last colonoscopy

_____

Date of last PSA

_____

WOMEN only
- ❒ Abnormal Pap Smear
- ❒ Abnormal Vaginal Discharge
- ❒ Bleeding lump
- ❒ Extreme menstrual pain
- ❒ Heavy menstrual bleeding
- ❒ Hot flashes
- ❒ Nipple discharge
- ❒ Painful intercourse
- ❒ Pelvic pain
- ❒ Vaginal discharge
- ❒ Other_____

Date of last menstrual period

_____

Date of last Pap Smear

_____

Date of last mammogram

_____

Date of last bone density

_____

Date of last colonoscopy

_____

Pregnancies____

Birth____ Miscarriage____

Prevention

Do you wear seat belts?	❒ Yes	❒ No	If no, why not? _____
Do you wear a bike helmet?	❒ Yes	❒ No	❒ N/A
Do you exercise regularly?	❒ Yes	❒ No	If yes, type, duration and number of times per week? _____
Do you smoke?	❒ Yes	❒ No	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	❒ Yes	❒ No	If yes, how much per week? _____
Do you drink coffee?	❒ Yes	❒ No	If yes, how many cups per day? _____
Do you drink tea?	❒ Yes	❒ No	If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	❒ Yes	❒ No	❒ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	❒ Yes	❒ No	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	❒ Yes	❒ No	If yes, explain: _____
Do you wish to be tested for AIDS?	❒ Yes	❒ No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	❒ Yes	❒ No	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	❒ Yes	❒ No	
Do you ever feel afraid of your partner?	❒ Yes	❒ No	❒ N/A
Do you have a "living will"?	❒ Yes	❒ No	
Do you have a donor card?	❒ Yes	❒ No	

Signatures

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient