IVCH Medical Group

Medical History Questionnaire

YOUR INFORMATION		
Full Name:	**Date of Birth:**	**Occupation:**
Living Status: ☐ **Lives Alone** ☐**With Spouse** ☐**Skilled Nursing** ☐ **With Other Family-Who?**		
Primary Care Physician:	**Cardiologist (if Applicable):**	

☐ **No Medications** **YOUR MEDICAITONS**

List all medications you take, both perscription & nonprescription below:

Are you taking Aspirin or anyother blood thinners? ☐**Yes** ☐ **No**

Medication/supplements Dose of medication	How often (Ex. Daily)	Why you taking (high BP etc.)	Medication/supplements Dose of medication	How often (Ex. Daily)	Why you taking (high BP etc.)

YOUR VACCINATIONS

Did you have a flu shot? ☐Yes ☐No	if yes date received : from:
Did you have a Pnemonia shot? ☐ Yes ☐ No	if yes date received : from:

☐ **No Allergies** **YOUR ALLERGIES**

Indicate all allergies you have to medications and/or food & describe reation below: Common reactions include-Anaphylaxis(life Threatening), Hives, Itching, Nausea/Vomiting, Trouble breathing ☐ **Latex** ☐ **Adhesive Tape**

Allergic to	Reaction	Allergic to:	Reaction

YOUR PHARMACY INFORMATION

Pharmacy Name:	**City:**

☐**No Relevant Medical History** **YOUR PAST MEDICAL HISTORY**

Disease Type	Date of Onset	Disease type	Date of Onset
High Blood Pressure ☐ Yes ☐No		High Cholesterol ☐ Yes ☐No	
Kidney Disease ☐ Yes ☐ No		Osteoarthritis ☐ Yes ☐No	
Heart Disease: ☐ Yes ☐ No		Anxiety ☐ Yes ☐ No	
Diabetes I or II ☐ Yes ☐ No		Depression ☐ Yes ☐ No	
Peripheral Vascular Disease ☐ Yes ☐ No		Bipolar Depression ☐ Yes ☐ No	
Pulmonary Embolism ☐Yes ☐ No		Lung Disease-Type: ☐ Yes ☐ No	
DVT/Blood clots-Leg or Lung ☐ Yes ☐ No		Ulcers ☐ Yes ☐ No	
Cancer-Type: ☐ Yes ☐ No		GERD ☐ Yes ☐ No	
Stents in Heart or Leg ☐ Yes ☐ No		Osteoporosis ☐ Yes ☐ No	
Sleep Apnea: USES CPAP ☐ Yes		HIV/AIDS ☐ Yes ☐ No	
Atrial Fibrillation ☐ Yes ☐ No		Hepatitis(A, B or C) ☐ Yes ☐ No	
Stroke ☐ Yes ☐ No		Fracture: ☐ Yes ☐ No	
Dementia/Forgetfulness ☐ Yes ☐ No		Back Problem-Type: ☐Yes ☐ No	
Are you taking Aricept or Numenda? ☐Yes ☐ No		Anemia ☐Yes ☐ No	
☐ Other		☐ Other	

Do you have any of the following:	
Coronary Artery Disease ☐ No ☐ Yes	Who treats you:
Heart Failure: ☐ No ☐ Yes	Who treats you:
Ischemic Vein Disease: ☐ No ☐ Yes	Who treats you
Have you had any of the following screenings with your PCP or Gynecologist:	
Mammogram: ☐ No ☐Yes, if yes Date:	Colorectal Screening: ☐No ☐Yes, if yes Date:

If you are Diabetic have you had the following:	
Yearly A1C blood test: ☐ No ☐ Yes if yes when: With:	**Eye exam:** ☐ No ☐ Yes if yes when: With:

☐ **No surgical History** **YOUR SURGICAL HISTORY**

Surgery Type: **Provider who preformed**	**Year of Surgery**	**Surgery Type:** **Provider who preformed**	**Year of Surgery**
☐ Hip Replacement- RT/LT		☐ Fracture-Type:	
☐ Knee Replacement- RT/LT		☐ Pacemaker	
☐ Shoulder/ Rotator Cuff- RT/LT		☐ Heart Surgery or Stents	
☐ Carpal Tunnel-RT/LT		☐ Spine-Type/Level:	
☐ Knee Scope-Type:		☐ Back Surgery	
☐ Lower Leg Vascular Surgery or Stents		☐ Other	

Any additional Surgical information:

Have you ever had general anesthesia? No☐ Yes ☐
If Yes, please explain any problems related to general anesthesia:

☐ **Family History Unknown** **YOUR FAMILY HISTORY**

Mother	**Father**	**Sister**	**Brother**
☐ Alive & Well	☐ Alive & Well	☐ Alive & Well	☐ Alive & Well
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Hypertension	☐ Hypertension	☐Hypertension	☐ Hypertension
☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke
☐ Cancer-Type:	☐ Cancer-Type:	☐ Cancer-Type:	☐ Cancer-Type:
☐ Blood Clot-Leg or lung	☐ Blood Clot-Leg or lung	☐ Blood Clot-Leg or lung	☐ Blood Clot-Leg or lung
☐ Respirtory issues	☐ Respirtory issues	☐ Respirtory issues	☐ Respirtory issues
☐ Other:	☐ Other:	☐ Other:	☐ Other:

YOUR SOCIAL HISTORY

Tobacco Use: ☐ Current ☐Former ☐ Never Type:_____ Packs/Day:_____ Years Used: _____ Have you ever tried to quit? ☐ Yes ☐No	**Alcohol Use:** ☐Yes ☐ No ☐ Former Type: ☐ Beer ☐ Wine ☐ Liquor How oftern do you drink:_____	**Caffeine Use:** ☐ Yes ☐ No Type:_____ Daily Amount:_____

YOUR ATTESTATION

I attest that the information provided above is complete & accurate as it will be utilized as part of my care and treatment plan

Patient Signature: **Date:**

If Minor, Guardian Signature: **Date:**

Patient Name: **DOB:**

Review of Systems: **Are you currently experiencing any of the following?**
(Please check all that apply for the following)

Musculoskeletal

☐ Joint Pains ☐ Elbow Pain
☐ Joint Swelling ☐ Wrist Pain
☐ Joint Stiffness ☐ Hand Pain
☐ Unsteady gait ☐ Hip Pain
☐ Neck pain ☐ Back Pain
☐ Shoulder Pain ☐ Knee Pain
☐ Ankle Pain ☐ Foot Pain
☐ Other:

Neurological

☐Numbness ☐ Weakness
☐ Tingling
☐ Dizziness
☐ Headaches
☐ Tremors
☐ Seizures
☐ Other:

Integumentary

☐ Poor Healing wounds
☐ Redness
☐ Rash
☐ itching
☐ Scarring/Keloids
☐ Bruising
☐ Other:

Constitutional/Symptoms

☐ Fatigue
☐ Unexpected weight loss
☐ Fever
☐ Chills
☐ Weight gain
☐ Other:

Hematologic/Lymphatic

☐ Easy Bleeding
☐ Easy Bruising
☐ Enlarged Lymph nodes
☐ Other:

Allergic/Immunologic

☐ Immunosuppression
☐ Allergic reaction to foods/ environment
☐ Other:

Cardiovascular

☐ Chest Pain
☐ Palpitations
☐ Fainting
☐ Shortness of Breath
☐ Irregular Heartbeat
☐ Heart murmur
☐ Leg Cramps
☐ High blood pressure (even if controlled with medication)
☐ Other:

Endocrine

☐ Excessive thirst or urination
☐ Heat/Cold intolerance
☐ Diabetic

ENT & Mouth

☐ Nose bleeds
☐ ringing in ears
☐ Hoarseness
☐ Hearing Aids
☐ Dentures or Bridge
☐ Other:

Eyes

☐ Corrective Lenses/Glasses
☐ Blurred vision
☐ Other:

Gastrointestinal/GI

☐ Heartburn
☐ Nausea/vomiting
☐ Constipation
☐ Diarrhea
☐ Bloody/tarry stools
☐ Other:

Genitourinary/GU

☐ frequent urination
☐ Incontinence
☐ Blood in urine
☐ Other:

Respiratory

☐ Shortness of breath
☐ Wheezing
☐ Cough
☐ Hurts to breath
☐ Other:

Psychiatric

☐ Nervousness
☐ Anxiety
☐ Depression
☐ Hallucinations
☐ Dementia/Forgetfulness