Alpharetta Family Medical Clinic

Medical History – Questionnaire

Name: _____ DOB: _____

Allergies to Medications, X-ray dyes, or other Substances ☐ Yes ☐ No
(If yes, please list name of medicine and type of reaction)

_____

Past Medical History
Please check off if you have had any problems with or are presently experiencing any of the following:

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Heart Disease
- ❑ TB
- ❑ Respiratory problem (breathing problem)

- ❑ Stomach problem
- ❑ Urinary problem
- ❑ Thyroid problem
- ❑ Weight loss
- ❑ Hemorrhoids
- ❑ Hepatitis

- ❑ Arthritis
- ❑ Lower back pain
- ❑ Anxiety/depression
- ❑ Impotence/erectile dysfunction
- ❑ Others
- ❑ None

Family History:
Please check off if any member of your family (parents & siblings) ever had the following condition(s):

	Which family member	Age when diagnosed
❑ Cancer	_____	_____
❑ High blood pressure	_____	_____
❑ Heart disease	_____	_____
❑ Diabetes	_____	_____
❑ Stroke	_____	_____
❑ Mental disorder	_____	_____
❑ Drug or Alcohol addiction	_____	_____

Immunization History, Preventive Exam, and Health Habit
Please check off if you have any of following immunization or examination done previously

	Date
❑ Hepatitis B vaccination	_____
❑ Pneumovax vaccination	_____
❑ Tetanus shot	_____
❑ Flu shot	_____
❑ Cholesterol checked	_____
❑ Prostate exam	_____
❑ Pap smear	_____
❑ Mammogram	_____

- ▪ Smoke Yes No
- ▪ Alcohol
  Often Sometime Rarely None
- ▪ Regular exercise Yes No
- ▪ Risk of Sexual transmitted disease Yes No
- ▪ Do you have "living will" Yes No

Gynecologic and Obstetric History:
Age at onset of periods _____ Regular irregular
# of Pregnancies _____ # of Births _____ # of Miscarriages _____

- ❑ Menopause
- ❑ Prolonged or abnormal bleeding
- ❑ Abnormal discharge
- ❑ History of abnormal Pap smear
- ❑ History of abnormal breast exam or mammogram
- ❑ Family history of breast cancer

Please sign _____ *Date* _____