

# PARKVIEW MEDICAL GROUP - Personal Medical Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Reason for visit today: \_\_\_\_\_

## PAST MEDICAL HISTORY

### Any Past Surgeries:

|   | What Surgery | When | Where |
|---|--------------|------|-------|
| 1 |              |      |       |
| 2 |              |      |       |
| 3 |              |      |       |
| 4 |              |      |       |

### Long Term Medical Problems:

|   | Problem | When diagnosed | Hospitalized for this problem |
|---|---------|----------------|-------------------------------|
| 1 |         |                |                               |
| 2 |         |                |                               |
| 3 |         |                |                               |

Drug allergies: \_\_\_\_\_

Please describe any reactions: \_\_\_\_\_

Current Medications (Prescription or frequent non-prescription):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other allergies: \_\_\_\_\_

### Immunizations

#### Date

Tetanus \_\_\_\_\_ Have you ever received a flu shot?  yes  no When? \_\_\_\_\_

Hepatitis B \_\_\_\_\_ Have you ever received a pneumonia shot?  yes  no When? \_\_\_\_\_

Last TB test \_\_\_\_\_ Have you ever had a positive reaction?  yes  no

Last complete physical: \_\_\_\_\_ Last eye exam: \_\_\_\_\_ Last dental exam: \_\_\_\_\_

Any recent blood or other test: \_\_\_\_\_

## SOCIAL HISTORY

What type of work do you do (or have you done)?: \_\_\_\_\_

Do you exercise regularly?  yes  no If yes, describe: \_\_\_\_\_

Have you ever smoked?  yes  no If you smoke now, how much? \_\_\_\_\_

If you don't smoke now, when did you quit: \_\_\_\_\_

How often do you drink alcohol and how much?: \_\_\_\_\_

Has drinking ever caused you a problem in any area of your life?  yes  no

Has drug use ever caused you a problem in any area of your life?  yes  no

Have you ever been physically hurt (slapped, kicked, punched or bruised) by anyone?  yes  no

**FAMILY HISTORY**

Has any member of your family ever had one or more of the following diseases? If so, please indicate who next to the problem.

|                           |                        |                          |
|---------------------------|------------------------|--------------------------|
| Cancer/Type _____         | Sickle Cell _____      | Gout _____               |
| Heart Disease _____       | TB _____               | Suicide _____            |
| Stroke _____              | Glaucoma _____         | Epilepsy _____           |
| Diabetes (sugar) _____    | Asthma _____           | Thyroid Disease _____    |
| Alcoholism _____          | High Cholesterol _____ | Bleeding Disorders _____ |
| High Blood Pressure _____ | Kidney Disorder _____  | Skin Cancer _____        |

If either of your parents or any siblings are deceased, please indicate age and cause of death:

**FOR WOMEN ONLY**

Age period began: \_\_\_\_\_ Age periods stopped, if applicable: \_\_\_\_\_

No. of pregnancies: \_\_\_\_\_ No. of miscarriages: \_\_\_\_\_

No. of deliveries: \_\_\_\_\_ Type of birth control used now: \_\_\_\_\_

Last PAP: \_\_\_\_\_ Last Period: \_\_\_\_\_ Have you ever had a mammogram?  yes  no When? \_\_\_\_\_

Do you have pain and/or bleeding during intercourse?  yes  no Do you experience any leakage of urine?  yes  no

Did your mother take DES or hormones while pregnant with you?  yes  no

**FOR MEN ONLY**

History of prostate disease?  yes  no Last prostate exam: \_\_\_\_\_

History of impotence?  yes  no Type of birth control used: \_\_\_\_\_

**FOR EVERYONE**

Have you ever had any of the following problems?

| Now                      | Past                     |                        | Now                      | Past                     |                            | Now                      | Past                     |                   |
|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive fatigue      | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing                   | <input type="checkbox"/> | <input type="checkbox"/> | Joint pain        |
| <input type="checkbox"/> | <input type="checkbox"/> | Night sweats           | <input type="checkbox"/> | <input type="checkbox"/> | Coughing blood             | <input type="checkbox"/> | <input type="checkbox"/> | Back pain         |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy bleeding/bruising | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain                 | <input type="checkbox"/> | <input type="checkbox"/> | Depression        |
| <input type="checkbox"/> | <input type="checkbox"/> | Transfusions           | <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles             | <input type="checkbox"/> | <input type="checkbox"/> | Suicidal thoughts |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches     | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                   | <input type="checkbox"/> | <input type="checkbox"/> | Sexual problem    |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures               | <input type="checkbox"/> | <input type="checkbox"/> | Change in stools           | <input type="checkbox"/> | <input type="checkbox"/> | STD's             |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye problems           | <input type="checkbox"/> | <input type="checkbox"/> | Blood in stool             | <input type="checkbox"/> | <input type="checkbox"/> | Physical abuse    |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear problems           | <input type="checkbox"/> | <input type="checkbox"/> | Frequent/painful urination |                          |                          |                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose bleeds            | <input type="checkbox"/> | <input type="checkbox"/> | Poor/slow urine stream     |                          |                          |                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast discharge/lump  |                          |                          |                            |                          |                          |                   |

Do you wear seatbelts?  yes  no Do you own a gun?  yes  no

Do you have a Living Will/Advance Directives?  yes  no

Any other questions or problems that concern you? \_\_\_\_\_