MONTH	DAY	YEAR

ATTENDING PHYSICIAN

McBRIDE ORTHOPEDIC HOSPITAL CLINIC

Acct # _____

Medical History Questionnaire

PLEASE PRINT — INFORMATION TO BECOME PART OF YOUR CONFIDENTIAL MEDICAL RECORD — **PLEASE PRINT**

NAME: FIRST	MIDDLE	LAST	AGE	SEX	RELIGION

(✓) CHECK REASON FOR SEEKING MEDICAL CARE

- ____ ILLNESS / PERSONAL REASONS
- ____ ROUTINE ANNUAL EXAM
- ____ JOB RELATED INJURY
- ____ COMPANY PHYSICAL
- ____ INSURANCE EXAM
- ____ PRE-EMPLOYMENT EXAM

DESCRIBE BELOW PROBLEMS YOU WISH TO DESCUSS WITH YOUR DOCTOR TODAY

1._____
2._____
3._____

SYSTEM REVIEW (✓) CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR FINDINGS
UNMARKED OR BLANK BOXES WILL BE CONSIDERED AS NEGATIVE FINDINGS

GENERAL	YES ☐	NO ☐	SKIN RASH
	YES ☐	NO ☐	LETHARGY / WEAKNESS
	YES ☐	NO ☐	LOSS OF INTEREST IN EATING
	YES ☐	NO ☐	ALWAYS HUNGRY
	YES ☐	NO ☐	TEND TO BE HOT OR COLD
	YES ☐	NO ☐	CHILLS / NIGHT SWEATS
	YES ☐	NO ☐	SLEEPING DIFFICULTIES
	YES ☐	NO ☐	OTHER
HEAD	YES ☐	NO ☐	FREQUENT HEADACHES
	YES ☐	NO ☐	DIZZY SPELLS
	YES ☐	NO ☐	FAINTING SPELLS /UNCONSCIOUSNESS
	YES ☐	NO ☐	OTHER
EYES	YES ☐	NO ☐	WEAR GLASSES
	YES ☐	NO ☐	EYESIGHT WORSENING
	YES ☐	NO ☐	SEE DOUBLE
	YES ☐	NO ☐	EYE PAINS OR ITCHING
	YES ☐	NO ☐	OTHER
EARS	YES ☐	NO ☐	DEAFNESS
	YES ☐	NO ☐	EARACHES OR DRAINAGE
	YES ☐	NO ☐	NOISE IN EARS
	YES ☐	NO ☐	OTHER
NOSE	YES ☐	NO ☐	CONGESTION / SNEEZING
	YES ☐	NO ☐	SINUS TROUBLE / HAY FEVER
	YES ☐	NO ☐	NOSE BLEEDS
	YES ☐	NO ☐	OTHER
THROAT	YES ☐	NO ☐	SORE THROAT OR TONGUE
	YES ☐	NO ☐	HOARSE VOICE
	YES ☐	NO ☐	DENTAL PROBLEMS
	YES ☐	NO ☐	GOITER / THYROID TROUBLE
	YES ☐	NO ☐	NECK PAINS OR LUMPS
	YES ☐	NO ☐	OTHER
LUNG & HEART	YES ☐	NO ☐	WHEEZING / COUGHING SPELLS
	YES ☐	NO ☐	COUGH UP PHLEGM
	YES ☐	NO ☐	SHORTNESS OF BREATH
	YES ☐	NO ☐	EMPHYSEMA
	YES ☐	NO ☐	COUGH UP BLOOD
	YES ☐	NO ☐	EXPOSED TO TB
	YES ☐	NO ☐	HEART RACING / PALPITATIONS
	YES ☐	NO ☐	HIGH BLOOD PRESSURE
	YES ☐	NO ☐	SWOLLEN FEET OR ANKLES
	YES ☐	NO ☐	CHEST PAINS
	YES ☐	NO ☐	HEART ATTACK
	YES ☐	NO ☐	HEART MURMUR
	YES ☐	NO ☐	OTHER
GI	YES ☐	NO ☐	HEART BURN OR INDIGESTION
	YES ☐	NO ☐	BELCHING OR NAUSEA
	YES ☐	NO ☐	JAUNDICE
	YES ☐	NO ☐	DIFFICULTY SWALLOWING
	YES ☐	NO ☐	STOMACH PAINS
	YES ☐	NO ☐	VOMITING BLOOD
	YES ☐	NO ☐	CONSTIPATION
	YES ☐	NO ☐	RECENT CHANGE IN BOWEL HABITS
	YES ☐	NO ☐	LOOSE BOWELS / DIARRHEA
	YES ☐	NO ☐	BLACK OR BLOODY STOOLS
	YES ☐	NO ☐	PAIN IN RECTUM
	YES ☐	NO ☐	HEMORRHOIDS
	YES ☐	NO ☐	AMOEBA / PARASITES
	YES ☐	NO ☐	OTHER
GU	YES ☐	NO ☐	FREQUENT NIGHT OR DAY VOIDING
	YES ☐	NO ☐	BURN ON URINATION
	YES ☐	NO ☐	PUS OR BLOOD IN URINE
	YES ☐	NO ☐	DIFFICULTY STARTING URINE
	YES ☐	NO ☐	DRIBBLING WITH COUGHING / SNEEZING
	YES ☐	NO ☐	OTHER KIDNEY DISEASE
	YES ☐	NO ☐	SEX DIFFICULTIES
	YES ☐	NO ☐	OTHER
NERVOUS	YES ☐	NO ☐	CONVULSIONS / SEIZURES / EPILEPSY
	YES ☐	NO ☐	STROKE / PARALYSIS
	YES ☐	NO ☐	DIFFICULTY MAKING DECISIONS
	YES ☐	NO ☐	MEMORY PROBLEMS
	YES ☐	NO ☐	CRY OFTEN / DEPRESSED / FEEL SAD
	YES ☐	NO ☐	WORRY A LOT
	YES ☐	NO ☐	CONSIDERED SUICIDE
	YES ☐	NO ☐	OTHER
MISCELLANEOUS	YES ☐	NO ☐	BLEED / BRUISE EASILY
	YES ☐	NO ☐	ANEMIA / LOW BLOOD
	YES ☐	NO ☐	BLOOD DISEASE
	YES ☐	NO ☐	ENLARGED GLANDS / NODES
	YES ☐	NO ☐	ACHING MUSCLES / JOINTS
	YES ☐	NO ☐	VARICOSE VEINS
	YES ☐	NO ☐	LEG CRAMPS / PAINS
	YES ☐	NO ☐	PAINFUL FEET
	YES ☐	NO ☐	CANCER
	YES ☐	NO ☐	PROLONGED FEVER
	YES ☐	NO ☐	OTHER

Physician Sig_____

Name_____ Acct # _____

(✓) CHECK KNOWN ALLERGY OR REACTION TO MEDICATIONS LIST ANY NOT SHOWN	✓	MEDICATION ALLERGIES	✓	MEDICATION ALLERGIES	✓	MEDICATION ALLERGIES
	☐	ANTIBIOTICS	☐	SEDATIVES	☐	NONE
	☐	CODEINE	☐	SULFA	☐	
	☐	PENICILLIN	☐	X-RAY DYES	☐	

LIST MEDICATIONS / DRUGS THAT YOU ARE CURRENTLY TAKING

MEDICATIONS / DRUGS	STRENGTH	DOSAGE

WHICH DRUGS DO YOU TAKE?

- ☐ ASPIRIN
- ☐ TRANQUILIZERS
- ☐ BIRTH CONTROL PILLS
- ☐ HORMONES
- ☐ LAXATIVES
- ☐ ANTACIDS
- ☐ VITAMINS
- ☐ ANTI-DEPRESSANTS

(✓) CHECK ANY ITEMS BELOW WHICH YOU ARE EXPOSED TO BY BREATHING OR SKIN CONTACT

- ☐ CHEMICALS_____
- ☐ DUST _____
- ☐ TOXINS_____
- ☐ FUMES_____
- ☐ SPRAYS _____
- ☐ INSECTICIDES_____
- ☐ OTHER (EXPLAIN) _____

PAST HISTORY (✓) CHECK BELOW ANY PROBLEMS YOU HAVE NOW OR THAT YOU HAVE HAD IN YOUR PAST

- ☐ ASTHMA
- ☐ PNEUMONIA
- ☐ TUBERCULOSIS
- ☐ HEART TROUBLE
- ☐ RHEUMATIC FEVER
- ☐ CIRRHOSIS
- ☐ HEPATITIS
- ☐ ULCERS
- ☐ PANCREATITIS
- ☐ GALLBLADDER PROBLEMS
- ☐ DIABETES
- ☐ KIDNEY STONE
- ☐ VENEREAL DISEASE
- ☐ MUMPS / MEASLES
- ☐ POLIO / MENNINGITIS

PLEASE INDICATE PREVIOUS MAJOR ILLNESS SURGERY OR INJURY	DEFINE PROBLEM	WHERE DID IT HAPPEN	YEAR	DIFFICULTIES NOW?

SOCIAL HISTORY

WEIGHT HISTORY

PRESENT WEIGHT _____ lbs

USUAL WEIGHT _____ lbs

WEIGHT CHANGE DURING PAST YEAR

GAINED_____lbs

LOST_____lbs

HOW MANY MEALS DO YOU EAT DAILY?

HABIT HISTORY

SMOKING

NEVER☐ VAPOR☐

PIPE☐ PACKS PER DAY _____

CIGAR☐ NO. OF YEARS _____

CHEW☐ YEARS STOPPED_____

ALCOHOL

NEVER ☐ OCCASIONAL☐

MODERATE ☐ HEAVY☐

COFFEE

CUPS PER DAY

MARITAL STATUS

- ☐ SINGLE
- ☐ MARRIED
- ☐ WIDOWED
- ☐ DIVORCE
- ☐ SEPARATED

EDUCATION (SHOW YEARS COMPLETED)

- ☐ GRADE
- ☐ HIGH
- ☐ BUSINESS OR VOCATIONAL
- ☐ COLLEGE

PREVIOUS PHYSICIAN

TYPE OF WORK OR OCCUPATION

FAMILY HISTORY

PARENTS	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH	NUMBER OF YOUR BROTHERS	NUMBER OF YOUR SISTERS	CHILDREN	NUMBER LIVING IN YOUR HOUSEHOLD
MOTHER							
FATHER							

HAS ANYONE IN YOUR IMMEDIATE FAMILY (FATHER, MOTHER, BROTHERS OR SISTERS) HAD ANY OF THE MEDICAL PROBLEMS LISTED BELOW? IF SO, WHO?

ALLERGY	YES ☐	NO ☐	TUBERCULOSIS	YES ☐	NO ☐	STROKE	YES ☐	NO ☐
ASTHMA	YES ☐	NO ☐	THYROID TROUBLE	YES ☐	NO ☐	HEART TROUBLE	YES ☐	NO ☐
DIABETES	YES ☐	NO ☐	SUICIDE	YES ☐	NO ☐	HIGH BLOOD PRESSURE	YES ☐	NO ☐
CANCER	YES ☐	NO ☐	MENTAL ILLNESS	YES ☐	NO ☐			
ULCER	YES ☐	NO ☐	BLEEDING TENDENCY	YES ☐	NO ☐	OTHER_____		

PHYSICIANS SIGNATURE _____

McBRIDE
ORTHOPEDIC HOSPITAL
CLINIC

MEDICATION RECONCILIATION

Date: _____ **Patient's Name:** _____

DOB: _____ **Medical Record #:** _____

☐ **No Known Drug Allergies** **Allergies/Reactions:** _____

_____

***LIST ALL THE MEDICATIONS THAT YOU ARE TAKING, INCLUDING SUPPLEMENTS, OVER THE COUNTER, INHALERS, EYE DROPS, AND HERBALS**

☐ **Patient is not taking any medications**

Medication/ Supplement/ Over the Counter	Dosage e.g. mg, unit, mcg	How is the Medication Taken (e.g. oral, injection)	How often is the Medication Taken (e.g. daily, twice daily)	Prescribing Physician