

MARK. D ARON PHD, LLC

MEDICAL HISTORY QUESTIONNAIRE

TODAY'S DATE: _____

*****Since this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately and completely as possible. All information is kept confidential. *****

NAME: _____ *Male/ Female* AGE: _____ DOB: _____

Providers

Referring Provider: _____ Primary Care Provider _____

Cardiologist: _____ Any Other Provider assisting in your care: _____

Why are you here today? _____

Past and Present Medical Problems

High blood pressure Yes/ No Heart attack Yes/ No High cholesterol Yes/ No Stroke/TIA Yes/ No

Heart Failure Yes/ No Atrial Fib/Arrhythmia Yes/ No PFO/ Hole in Heart Yes/ No Cancer Yes/ No

Coagulopathy/Clotting disorder Yes/ No Diabetes Yes/ No Kidney disease Yes/ No Thyroid disease Yes/ No

Other Past Medical History not listed: _____

Surgical History

Please list any surgeries that you have had in the past. Some of the more common ones are listed below Please circle and date if relevant:

Amputation site _____ Date of surgery _____, Aneurysm repair/site _____ Date of surgery _____

Bladder/Prostate repair/ Date of surgery _____, Carotid surgery/ Date of surgery _____,

Cataract/ Date of surgery _____, Heart stent/bypass/ Date of surgery _____,

Laparoscopy (abdominal scope)/ Date of surgery _____, Lower extremity bypass/Date of surgery _____,

Pacemaker / Date of implant _____, Prostate repair/Date of surgery _____

Orthopedic surgeries (Knee, shoulder/rotator cuff, hip replacement) Date of surgery _____

(Circle all that apply)

Other surgeries or procedures _____

Do you drink alcohol? Current everyday Current someday Former Never Unknown

Beer/Wine/Liquor *(circle all that apply)* How many per week? _____

Do you use recreational drugs? Current everyday Current someday Former Never Unknown

Have you ever used tobacco? Current everyday Current someday Former Never Unknown

How many packs per day **do you or did you** smoke? < 1/2 1/2 1 1 1/2 2 2 1/2 3

How many years **did you or have you** smoked? _____ When did you quit? _____

Review of Systems <i>Please circle if you have any of the following:</i>		
◇ Constitutional	◇ Respiratory	◇ Neurological
Fatigue/Drenching Night Sweats	Asthma/ Anesthetic problems	Migraines/Headache/Vertigo
Fever/Chills	COPD/Pneumonia/Emphysema	Temporary/Paralysis Arm/Leg/Face
General health excellent/Poor	Coughing/coughing up blood	Tingling/Numbness
Unexplained weight loss/Gain	Hoarseness/Obstructive Sleep Apnea	Speech difficulties/Seizures
◇ Eyes	Oxygen Dependent LPM _____	◇ Musculoskeletal
Blurry vision/Double vision	Shortness of Breath with Exertion	Artificial knee or hip joint
Cataracts/ Macular degeneration	Shortness of breath /Wheezing	Back pain/Joint pain
Glasses/Contacts/Blindness	Tuberculosis or exposure	Degenerative/Osteoarthritis
Glaucoma/Retinopathy	◇ Gastrointestinal	Muscle pain/Weakness/Cramps
Partial loss of vision/blind spots	Abdominal pain/Blood in stool	Rheumatoid Arthritis
◇ Ears/Nose/Mouth/Throat	Black or Tarry stool	◇ Endocrine
Dentures/Difficulty swallowing	Bloating/Diarrhea/Constipation	Cold/Heat intolerance
Hearing Loss/ringing in ears	Loss of appetite/Heartburn	History of drug resistant infection
Prolonged Nose bleeds	Nausea/Vomiting	
Voice change	Ulcer disease/Pain after eating	◇ Psychiatric
◇ Cardiovascular	Vomited blood	Anxiety/Depression
Ankle Swelling /Varicosities	◇ Genitourinary	Confusion/Memory loss
Calf pain with/without exercise	Impotence	Difficulty sleeping
Chest pain with exertion/Exercise	Incontinence /Difficulty Voiding	
Chest pain/ Heart murmur	Kidney stones	◇ Heme/Lymphatic/Immune
Dyspnea on exertion/Syncope	Suprapubic/Indwelling Catheter	Anemia/Low platelet count
Irregular/Rapid heart rate	Urgency/Blood in Urine	Bleeding disorder/Easy bleeding
Leg Pain/Cramping in legs at night	◇ Integumentary (Skin)	Easy bruising
	New skin lesions/Skin Cancer	Lymphoma/Leukemia
	Rash/Persistent itching	Frequent illnesses
	Unhealed/Delayed healing of sores	