Frederick Health
Medical Group

Annual Medical History Questionnaire

Name: _____ Date: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Reason for visit today: _____

Do you have any language or hearing needs? If so, describe _____

	Past surgeries	When	Where
1			
2			
3			
4			

	Chronic problems	Year diagNosed	Hospitalized for problem?
1			
2			
3			
4			
5			

Preferred Pharmacy and Location _____

	Current medications		Current medications
1		6	
2		7	
3		8	
4		9	
5		10	

Any kNown allergies: _____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Medical History

Now Past Now Past Now Past

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☐	☐	Excessive fatigue	☐	☐	Night sweats	☐	☐	Easy bleeding/bruising
☐	☐	Transfusions	☐	☐	Frequent headaches	☐	☐	Seizures
☐	☐	Eye problems	☐	☐	Ear problems	☐	☐	Breast discharge/lump
☐	☐	Nose bleeds	☐	☐	Wheezing	☐	☐	Cough
☐	☐	Chest pain	☐	☐	Swollen ankles	☐	☐	Jaundice
☐	☐	Change in stool	☐	☐	Suicidal thoughts	☐	☐	Physical abuse
☐	☐	STD/STI's	☐	☐	Sexual problems	☐	☐	Frequent urination

Name: _____ Date of Birth: _____

	Date		Date
Tetanus	_____	Have you ever had a flu shot?	_____
Hepatitis B	_____	Ever received a pneumonia shot?	_____
Last Physical?	_____	Ever received a shingles shot?	_____
Last eye exam?	_____	Last stool/hemoccult testing?	_____
Last coloNoscopy?	_____	Last Dexa scan?	_____
Last dental exam?	_____	Last stress test?	_____

What type of work do you do or have you done?
_____

What is your education level? ☐ Less than high school ☐ High school diploma or equivalent ☐ Tech education ☐ Associates degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctoral

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Do you exercise regularly? Yes No If Yes, describe.

_____

Do you currently smoke? Yes No If Yes, how much

_____

Have you ever smoked? Yes No If Yes when did you quit

_____

Are you/have you been exposed to secondhand smoke? Yes No

Do you have an active social life? Yes No Do you feel isolated? Yes No

Do you feel you have strong social support? Yes No

How often do you drink alcohol and how much?

_____

Has alcohol ever caused a problem in any area of your life?

_____

Has drug use ever caused you a problem in any area of your life?

_____

Any history of sexually transmitted diseases or high-risk sexual behavior?

_____

Do you live alone and if Not who else is in the home?

_____

Do you understand eNough about health resources in your community to meet your needs? Yes No

Do you have an Advanced Directive? Yes No If yes, where is it on file?

_____

Would you like additional information on Advanced Directives? Yes No

Do you have any questions about housing/food needs? Yes No

Name: _____ Date of Birth: _____

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 _____

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Epilepsy _____	Diabetes _____
Asthma _____	Thyroid disorder _____
Alcoholism _____	High Cholesterol _____
Bleeding disorder _____	High blood pressure _____
Kidney disorder _____	Mental health _____

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

_____

_____

For patients that are 65 years of age and older

Did you fall in the past year? ☐ Yes ☐ No How many? _____ Did the fall(s) result in an injury? ☐ Yes ☐ No

Do you use a walking aid or has one been recommended? ☐ Yes ☐ No ☐ N/A
Details:_____

For women only

Age period began _____ Age periods stopped
_____

No. of pregnancies _____ No. of miscarriages
_____

No. of deliveries _____ Type of birth control used
_____

Last Pap _____ Last period _____ Ever had a mammogram ☐ Yes ☐ No When?
_____

Do you have pain or bleeding during intercourse ☐ Yes ☐ No Do you experience leakage of urine ☐ Yes ☐ No

For men only History of prostate disease? ☐ Yes ☐ No Last prostate exam
_____

History of impotence? ☐ Yes ☐ No

For patients 13 years of age and older

Over the past two weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No

Over the past two weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ No

Diabetics only

Last diabetic eye exam?_____ If diabetic, what brand/model of meter:
_____

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Glucometer supplies from? _____	Times per day do you test?
_____	