

Medical History Questionnaire
CHARLES O. BRANTIGAN, MD

Patient Name: _____ **Date:** _____

Are you allergic to any drugs or medications? YES NO If so, please indicate which ones:

What are you being seen for today? _____

Briefly describe your present medical symptoms and include the date of onset:

Past Medical History:

Childhood illnesses (Please circle): Measles, mumps, chicken pox, whooping cough, diphtheria, smallpox, scarlet fever, rheumatic fever, arthritis.

List other serious illnesses or hospitalizations:

List any operations that you have had and the year:

What medicines are you currently taking, including prescribed, herbals, vitamins & minerals? (Please list name, dose and how many times each day you take them):

Are you an active person? Yes **No**
 Do you exercise regularly Yes **No**
 Do you participate in sports? Yes **No**
 Describe any physical limitations

Have you ever had cancer? **Yes** No
 If so what kind?

Have you ever needed psychiatric help? **Yes** No

Blood:

Have you ever had any blood disease? **Yes** No

Do you bleed easily? **Yes** No

Does your blood clot too easily? **Yes** No

Do you have anemia? **Yes** No

Skin:

Is your skin healthy? Yes **No**

Do you have any skin diseases? **Yes** No

Do you have skin ulcers? **Yes** No

Endocrine:

Have you ever had a thyroid condition? **Yes** No

Have you ever taken thyroid pills? **Yes** No

Do you have diabetes? **Yes** No

Do you have unusual thirst? **Yes** No

Have you had unusual weight gain or loss? **Yes** No

Head and Neck:

Do you have significant headaches? **Yes** No

Do you have fainting spells? **Yes** No

Do you occasionally lose vision in one eye? **Yes** No

Have you ever had a TIA **Yes** No

Do you know of any problems with the arteries in your neck? **Yes** No

Have your neck arteries been scanned? **Yes** No

Have you ever had a convulsion? **Yes** No

Have you ever been knocked out? **Yes** No
 Have you had spells of weakness or paralysis of arm or leg? **Yes** No

Eyes, ears nose and throat:

Is your vision good? Yes **No**

Do you ever see double? **Yes** No

Is dizziness a problem for you? **Yes** No

Have you had sinus infections? **Yes** No

Do you have trouble with hearing? **Yes** No

Lungs:

When was your last chest x ray?

Where was it taken?

Are you short of breath? **Yes** No

Are you short of breath with exercise? **Yes** No

Do you have a chronic cough: **Yes** No

Do you cough up much phlegm? **Yes** No

Have you ever coughed up blood? **Yes** No

Have you ever had:

Tuberculosis **Yes** No

Pneumonia **Yes** No

Asthma **Yes** No

Pleurisy **Yes** No

Emphysema **Yes** No

Bronchitis **Yes** No

Heart

Do you have heart disease: **Yes** No

If so what kind:

Have you ever had a heart attack? **Yes** No

Do you have angina? **Yes** No

Have you ever had heart failure? **Yes** No

Are you bothered with chest pain? **Yes** No

Have you ever taken nitroglycerin? **Yes** No

Have you ever had high blood pressure? **Yes** No

Does shortness of breath awaken you at night? **Yes** No

Is ankle swelling a problem? **Yes** No

When was your last EKG?

Where was it taken?

Was it abnormal? **Yes** No

Breasts (women): (remember that regular breast exams by yourself and

your family physician are important and are not part of a vascular exam)
 When was your last mammogram?
 Do you check your breasts for lumps? **Yes** **No**
 When were your breasts last examined by a physician?

Female organs (women): (remember that regular pelvic exams by your family physician of gynecologist and pap smears are important and are not a part of a vascular exam)
 When was your last Pap smear?
 When was your last pelvic exam?

Gastrointestinal:
 Is your appetite good? **Yes** **No**
 Do you have heartburn or indigestion? **Yes** **No**
 Do you have stomach pains? **Yes** **No**
 Do you take stomach medicine? **Yes** **No**
 Do fried or fatty foods bother you? **Yes** **No**
 Is vomiting a problem for you? **Yes** **No**
 Do you have gall bladder disease or gall stones? **Yes** **No**
 Have you had your gall bladder removed? **Yes** **No**
 Do you have abdominal cramps? **Yes** **No**
 Do you move your bowels daily? **Yes** **No**
 Is constipation a problem? **Yes** **No**
 Is diarrhea a problem for you? **Yes** **No**
 Do you have pain during bowel movements? **Yes** **No**
 Have you ever had blood in your stool? **Yes** **No**
 Have you ever had black tarry stools? **Yes** **No**
 Have you ever had ribbon like stools? **Yes** **No**
 When was your last rectal exam: (note that such exams by your family physician are important and are not part of a vascular exam)?

Urinary:
 Do you have burning when passing urine? **Yes** **No**
 Do you have loss of bladder control? **Yes** **No**
 Do you have blood in your urine? **Yes** **No**

Have you ever had an infection in your urine? **Yes** **No**
 Do you have trouble urinating? **Yes** **No**
 Do you have to get up at night to pass urine? **Yes** **No**

If so how often:

Men:
 Have you ever had prostate problems? **Yes** **No**
 When was your prostate last checked: (It is important that this be done on a regular basis and it is not part of a vascular exam)

Extremities
 Do you have pain in your legs at rest? **Yes** **No**
 Do you have pain in the calves, thigh or hip while walking? **Yes** **No**
 If so how far can you walk without pain?
 Does the pain stop when you stop to rest? **Yes** **No**
 Do you have numbness, tingling or burning of your feet? **Yes** **No**
 Do your ankles swell? **Yes** **No**
 Have you ever had blood clots in your legs? **Yes** **No**
 Have you ever had an ulcer on your legs? **Yes** **No**

Musculoskeletal:
 Do you have joint pains? **Yes** **No**
 Do you have rheumatism? **Yes** **No**
 Have you ever consulted with a rheumatologist? **Yes** **No**
 Do you have tendonitis, or fibromyalgia? **Yes** **No**
 Do you have thoracic outlet syndrome? **Yes** **No**