Female and Male Medical History Questionnaire:

List **chronic health problems** you have or are currently treated for	Since	List any **Hospitalizations**	Date
1)		1)	
2)		2)	
3)		3)	
4)		4)	
5)		5)	
6)		6)	

List any **Surgeries**	Date	List any **Injuries**	Date
1)		1)	
2)		2)	
3)		3)	
4)		4)	
5)		5)	

List all drugs you presently use regularly or take occasionally			**Allergies**	
Medication	Strength	Dose	Are you allergic to	List other allergies
1)			☐ Penicillin	1)
2)			☐ Sulfa drugs	2)
3)			☐ Codeine or Morphine	3)
4)			☐ Latex	4)
5)			☐ Adhesive tape	
6)			☐ Iodine (shellfish,contrast)	☐ no allergies known

Social history

Marital status	**Tobacco use**	**Alcohol Use**	**Drug Use**
☐ Single	☐ Never	☐ Never	☐ none
☐ Married	☐ Quit _______years ago	☐ Quit ________ years ago	☐ Quit ________ years ago
☐ Divorced	☐ Smoker	☐ 1-3 drinks ☐ daily	☐ Marihuana
☐ Separated	______☐ cigarettes ☐ daily	☐ 4-6 drinks ☐ weekly	☐ Cocaine
☐ Widowed	☐ packs ☐ weekly	☐ > 6 drinks ☐ monthly	☐ Other
Occupation		☐ Retired	☐ Disabled

Family History

Relative	Alive	Health	Died	Cause	Age	Relative	Alive	Health	Died	Cause	Age
Father	☐		☐			Sisters	☐☐☐		☐☐☐		
Mother	☐		☐			Sons	☐☐☐		☐☐☐		
Brothers	☐☐☐		☐☐☐			Daughters	☐☐☐		☐☐☐		

Is there family history of

☐ Cancer	☐ Diabetes	☐ Heart disease	☐ Kidney disease
☐ Prostate cancer	☐ Stroke	☐ Urinary abnormality	☐ Urinary stones

PATIENT NAME	**AGE**