



OLIVE BRANCH FAMILY MEDICAL CENTER

Medical History Questionnaire

Patient Name: _____

Gender : M / F Date of Birth: _____

Please fill in appropriate marks like this: ● not like this: ⊖ ⊗

Have you been diagnosed with any of the following medical conditions:

- | | | |
|---|--|--|
| <input type="radio"/> Abnormal Heart Rhythm | <input type="radio"/> Kidney Stones | <input type="radio"/> Ear Infections |
| <input type="radio"/> Alcoholism | <input type="radio"/> Low Blood Pressure/Hypotension | <input type="radio"/> Febrile Seizure |
| <input type="radio"/> Anxiety | <input type="radio"/> Lung Disease | <input type="radio"/> None of the Above |
| <input type="radio"/> Arteriosclerosis | Fatigue: | Surgeries – Procedures |
| <input type="radio"/> Arthritis | <input type="radio"/> Marked | <input type="radio"/> Appendix Removal |
| <input type="radio"/> Asthma | <input type="radio"/> Moderate | <input type="radio"/> Blood Transfusions |
| <input type="radio"/> Blood Clots | <input type="radio"/> Muscle Disease | <input type="radio"/> CABG (Heart Surgery) |
| <input type="radio"/> Bronchitis/Broncholitis | <input type="radio"/> Psychiatric Illness | <input type="radio"/> Gallbladder Removal |
| <input type="radio"/> Cancer | <input type="radio"/> Psychotic Illness | <input type="radio"/> Hernia Repair |
| <input type="radio"/> Cholesterol/Triglyceride Disorder | <input type="radio"/> Pulmonary Hypertension | Hysterectomy: |
| <input type="radio"/> COPD/Pulmonary Diseases | <input type="radio"/> Renal Disease | <input type="radio"/> Total |
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Seizure Disorder | <input type="radio"/> Partial |
| <input type="radio"/> Depression | <input type="radio"/> Sleep Disorders | <input type="radio"/> Pacemaker |
| <input type="radio"/> Diabetes | <input type="radio"/> Stomach/GI Disorders | <input type="radio"/> Tonsils Removed |
| <input type="radio"/> Drug Addiction/Dependency | <input type="radio"/> Stroke | <input type="radio"/> Tubal Ligation |
| <input type="radio"/> Fainting/Dizzy Spells | <input type="radio"/> Thyroid Disorders | <input type="radio"/> TURP |
| <input type="radio"/> Gallbladder Disease | <input type="radio"/> Tremor | <input type="radio"/> Stomach Surgery |
| <input type="radio"/> Glaucoma | <input type="radio"/> Ulcer Disease | <input type="radio"/> Thyroid Surgery |
| Headaches: | <input type="radio"/> Urinary Infections | <input type="radio"/> Spleen Surgery |
| <input type="radio"/> Migraine | <input type="radio"/> Weight Fluctuations | <input type="radio"/> None of the Above |
| <input type="radio"/> Tension | <input type="radio"/> None of the Above | |
| <input type="radio"/> Hearing Problems | Children, Ages 10 and under | <input type="radio"/> Other |
| <input type="radio"/> Hiatal Hernia | <input type="radio"/> Problems In-Utero | |
| <input type="radio"/> High Blood Press/Hypertension | <input type="radio"/> Premature Birth/Complications | |
| <input type="radio"/> Kidney Disease/Uremia | | |

Please check positive family medical history below:

	Deceased	Diabetes	Asthma	Cancer	Hypertension	Coronary Artery Disease
Mother:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Father:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please check positive social history below:

- Smoker: No Yes
- Alcohol: Never Rarely Occasional Heavy
- Recently Traveled Abroad: No Yes