

Adult Outpatient History Questionnaire

Past Medical/Surgical History:

Please list any testing you have had within the last 6 months (bloodwork, MRI, MRA, Catscan, other) and date it was performed:

Have you ever been hospitalized? Yes No Describe _____

Have you had any surgery? Yes No Describe _____

Have you had any Past Procedures? Yes No Describe _____

Family History:

Are you adopted? No Yes (if medical history of blood relatives known, describe below)

Father: Alive, Age: _____ Deceased, Cause of Death: _____

Mother: Alive, Age: _____ Deceased, Cause of Death: _____

Please list any illnesses in the following family members:

Father: _____ Mother: _____

Grandparents: _____ Sisters: _____

Brothers: _____ Children: _____

Other: _____

Have you ever been diagnosed in the past with any of the following?

	No	Yes	When did it start?	Was it resolved, if so when?
Arthritis				
Asthma				
Depression				
Diabetes				
Endocrine Disorder				
GI problems				
Heart disease				
High blood pressure				
High cholesterol				
Infectious disease				
Insomnia				
Kidney problems				
Lung problems				
Lyme Disease				
Memory Loss				
Migraine/Headache				
Psychiatric Illness				
Seizure				
Stroke/TIA				
Thyroid Disease				
Tuberculosis				
Urination at Night				
Other _____				

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Review of Systems:

Are you currently experiencing any of these symptoms?

Allergic/Immunological

- Seasonal allergies No Yes Describe _____
- Immune disorders No Yes Describe _____

Cardiovascular

- Chest pain, palpitations No Yes Describe _____
- Fainting No Yes Describe _____

Constitutional

- Fever, weight loss No Yes Describe _____

Ears/Nose/Mouth Throat

- No Yes Describe _____

Endocrine (thyroid)

- No Yes Describe _____

Eyes (glaucoma, cataracts)

- No Yes Describe _____

GI

- Blood in stool, nausea, vomit No Yes Describe _____

GU

- Pain with urination No Yes Describe _____
- Blood in urine No Yes Describe _____
- Sexual dysfunction No Yes Describe _____

Hematological/Lymphatic

- Bruising, lymph nodes No Yes Describe _____

Musculoskeletal

- Muscle aches, joint pain No Yes Describe _____

Neurologic

- Dizziness/spinning No Yes Describe _____
- Double vision No Yes Describe _____
- Headache No Yes Describe _____
- Hearing loss No Yes Describe _____
- Incoordination No Yes Describe _____
- Loss of vision No Yes Describe _____
- Memory loss No Yes Describe _____
- Numbness/tingling No Yes Describe _____
- Ringing in the ears No Yes Describe _____
- Sleep disturbances No Yes Describe _____
- Slurred speech No Yes Describe _____
- Weakness No Yes Describe _____

Psychiatric

- No Yes Describe _____

Respiratory

- Shortness of breath No Yes Describe _____
- Wheezing No Yes Describe _____

Skin/Breast

- Rash, lumps, bumps No Yes Describe _____