Patient History Questionnaire

Patient Name:____________________ Date: __________

Primary reason for seeing to Dr. Price: ____________________

Medical and Surgical History

List hospitalizations, surgeries, serious injuries

Have you ever had the following?

Condition		
Diabetes..........................	yes	no
Hypertension....................	yes	no
Cancer............................	yes	no
Stroke............................	yes	no
Heart trouble...................	yes	no
Arthritis/gout...................	yes	no
Convulsions.....................	yes	no
Bleeding tendency............	yes	no
Acute infections................	yes	no
Hereditary disease..............	yes	no
Gynecologic infection..........	yes	no

Social History (check all that apply)

Marital: single married separated divorced widowed

Alcohol: never rarely ______ drinks/ week

Tobacco: ▯ never ▯ quit ▯ ______ packs/ day for ___ years

Drugs: never ▯ have used ▯ use type ______

Caffeine (coffee/soft drinks) amount per day: ______

Prolonged exposure to : fumes ▯ dust ▯ solvents noise

Current Medications with Doses

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Cancer Screening History

Please provide the dates of the most recent testing:

Colonoscopy: ______

Mammogram: ______

Pap smear: ______

Medication Allergies and Reactions

1.
2.
3.
4.
5.
6.

Family Medical History

Specify current health status or cause of death, age or age at death, medical problems

Father: ______

Mother ______

Siblings ______

Children ______

patient signature: ______

provider signature: ______

Fredric V. Price, M.D. or Sharon L. Saginaw, PA-C