Office Use Only:
DOS: ________________
RAGHU KAPIL
Account#: ______________

Patient's name: _________________________________

Date of Birth________________________

MEDICAL HISTORY QUESTIONNAIRE

What is the reason for today's visit?
____
____

LIST OF ALL MEDICATIONS:

Name of Medication:	**MG:**	**Frequency:** Ex: 1 tablet daily twice a day, 2 tablet once per day

**If more space needed for medications can add on back of sheet.*

PAST MEDICAL HISTORY:

Please box any appropriate medical conditions you have been *diagnosed* with:

Anemia	Cancer: type-	Seizures
Asthma	Colitis	Stoke or TIA
Angina	Chlamydia	Schizophrenia
Alcohol Addiction	Diabetes Mellitus Type 1	MS
AIDS	Diabetes Mellitus Type 2	Heart Attack
Hypothyroidism	Depression	Hepatitis A , B or C
Hypothyroidism	Elevated Cholesterol	Peptic Ulcer Disease
Hyperthyroidism	Migraine Headaches	Kidney Stones
Hypertension	Emphysema	Glaucoma
Heart Murmur	Pneumonia	Gout
Heart Failure	Rheumatic Fever	Gonorrhea

Any other medical conditions you have been diagnosed with:
____
____

LIST ALL ALLERGIES TO MEDICATIONS & REACTIONS:
(ex: swelling, severe diarrhea, or hives)
____
____

LIST ANY SURGERIES YOU HAVE HAD:
Please include date, if possible (ex: C-section, appendectomy, tonsils removed)
____
____

DO YOU CURRENLY USE:

TOBACCO:
☐Currently ☐Never ☐Former
How many packs per day: ____________
Type of Tobacco: ___________________

ALCOHOL:
☐Currently ☐Socially ☐Never ☐Quit
Drinks per day: ______ Drinks/week:____
Type of Alcohol: ____________________

CAFFEINE:
☐Rare ☐Sometimes ☐Heavy(2 cups +/day)

RECREATIONAL DRUGS:
☐Currently ☐Never ☐Former
Substance(s): ____________________

MARITAL STATUS: ☐ Single ☐ Married
☐ Divorced ☐ Widowed ☐ Legally Separate

OCCUPATION: ☐Full time ☐Part time
☐Not Employed ☐Self Employed ☐Retired
☐Military ☐Student – part time or full time

SEXUALY ACTIVE: ☐Yes ☐No

EXERCISE: ☐Yes ☐No
Type: _____________________________
How many times per week_____________

PREVENTATIVE CARE: (date of last)
Tetanus(Tdap or TD) vaccine: __________
Flu vaccine: _________Pneumonia vaccine ________
Last Bone Density: ___________ Results: _________
Last Colonoscopy: ____________Results: _________
Last Diabetic Eye Exam: _______ Results: _________
Have you ever had blood transfusions: Yes No
If so when was the last time: _________

*****Pharmacy Name:*** ___________________
Address: ___________________________
Phone number: ______________________

FAMILY HISTORY:

Please check the appropriate family medical history:

Condition:	Father	Mother	Sister	Brother	Mother's dad	Mother's mom	Father's dad	Father's mom	Other:
Hypertension									
Heart Attack									
Diabetes									
Depression									
Schizophrenia									
Seizure									
Migraine headache									
Blood Disorder Type-									
Cancer Type-									

Patient's Children:

Name: Gender: DOB: Healthy

____ ☐Yes ☐No

____ ☐Yes ☐No

____ ☐Yes ☐No

____ ☐Yes ☐No

____ ☐Yes ☐No

____ ☐Yes ☐No

____ ☐Yes ☐No

____ ☐Yes ☐No

# of Adoptive Children:_____________________

OB/GYN HISTORY:

First day of last cycle (LMP) ________________

☐ Normal ☐ Abnormal

Date of Last Pap Smear:____________________

☐ Normal ☐ Abnormal

Date of Last Mammogram:__________________

☐ Normal ☐ Abnormal

Do you do self-breast exams:

☐ Yes ☐ No

PREGNANCIES:

# of total Pregnancies: ______________________

# of Pre Term Births:_______________________

# of Full Term Births: ______________________

# of Living Children: _______________________

# of Multiple Births: _______________________

# of C- Sections: ___________________________

V.B.A.C (Vaginal Birth After C-Sections)

Attempted? ☐ Yes ☐ No

# of Induced Abortions: ___________________

# of Spontaneous Abortions(miscarriage)________

# of Ectopic Pregnancies: ___________________