Mesa Family Physicians

For in-office use only
Chart #_____

PATIENT HISTORY QUESTIONNAIRE

Name:_____ **DOB:**_____ **Date:**_____

Preferred Communication: Cell phone # _____ (or) Home **#**_____

Gender: _____ **Preferred Language:** English / Spanish / Other **Marital Status:** _____

Race: Caucasian / Asian / Latino / African American / Other_____

Pharmacy Name & Number: _____

Medications: YES (list meds/over the counter supplements below)
No (I do not take medications or over the counter supplements)

Please list **ALL** the medications you take, including over the counter drugs or supplements.

Name of Medicine	Dosage & How often taken	Reason for taking this med

Allergies: Yes (list below) No Allergies

List all Allergies - such as food, medications, chemicals, etc.

Allergy	Reaction

Doctors: Please list all doctors currently involved in your care.

Name	Phone #	Reason

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Name: _____ **DOB:** _____ **Date:** _____

Family History: Please check box for past or present conditions.

Medical Problems	Mother	Father	Siblings	Grandparents
High Blood Pressure				
Lung Disease				
Bleeding Problems				
Diabetes				
Stroke				
Heart Disease				
Cancer				
Other				

____ Medical History Entered Above ____ I have no prior medical history of the above conditions

Past Medical History – Diagnosed: Check all that apply

☐ High Blood Pressure	☐ Bleeding Disorder	☐ Hepatitis B or C
☐ Atrial Fibrillation	☐ COPD/Chronic Bronchitis	☐ Anemia
☐ Asthma	☐ Diabetes	☐ Infections
☐ Sleep Apnea	☐ Stroke	☐ Bowel Disease
☐ Acid Reflux	☐ Kidney Problems	☐ Rheumatic Fever
☐ Heart Disease	☐ DVT	☐ Seizures
☐ High Cholesterol	☐ HIV	☐ Thyroid Disease
☐ Gout	☐	☐
☐ Cancer (please write in):	Any Mental Illness: ☐ Depression ☐ Bipolar ☐ Anxiety ☐ Other	☐ Other medical problems not listed:

Past Surgical, Hospitalization & Injury History: Please list all surgeries, hospitalizations & injuries and the dates they were performed. (If none, please write N/A).

☐ Hysterectomy	☐ Tonsils/Adenoids	☐ Gall Bladder
☐ Ovaries removed? yes / no	☐ Muscle/Joint surgeries	☐ Colonoscopy
☐ Appendix	☐ Cataracts	☐
☐ Any Biopsies? (please list) _____ _____	☐ Other (explain) _____ _____	_____ _____

Personal Social History:

Tobacco Use: (never) (quit/when: _____) (current smoker/ _____ packs a day)
Alcohol Use: (never) (rarely) (moderate) (daily) How Much? _____
Drug Use: (never) Type/Frequency:_____

Occupation:_____

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Review of Systems: (Please circle yes or no)

General/Constitutional:
Weight Gain? Yes / No
Weight Loss? Yes / No
Fever? Yes / No
Fatigue? Yes / No
Change in Appetite? Yes / No
Night Sweats? Yes / No

Ophthalmologic:
Blurred double vision? Yes / No
Glasses/contacts? Yes / No
Glaucoma? Yes / No
Eye/Disease/Injury? Yes / No

ENT:
Ringing in ears? Yes / No
Sore throat? Yes / No
Sinus problems? Yes / No
Decreased hearing? Yes / No
Nosebleed? Yes / No

Cardiovascular:
Chest pain at rest? Yes / No
Chest pain w/exertion? Yes / No
Palpitations? Yes / No
Heart trouble? Yes / No
Fluid accumulation in legs? Yes / No

Respiratory:
Shortness of breath? Yes / No
Shortness of breath w/ exertion? Yes / No
Wheezing/Asthma? Yes / No
Coughing up blood? Yes / No

Endocrine:
Excessive thirst? Yes / No
Thyroid disease? Yes / No
Hormone problem? Yes / No

Musculoskeletal:
Leg cramps? Yes / No
Muscle aches? Yes / No
Joint stiffness? Yes / No
Swollen joints? Yes / No
Joint pain? Yes / No

Genitourinary:
Kidney stones? Yes / No
Blood in urine? Yes / No
Testicle pain? Yes / No
Menstrual problems? Yes / No

Neurologic:
Tingling/Numbness? Yes / No
Convulsions/Seizures? Yes / No
Frequent headache? Yes / No
Paralysis/Tremor? Yes / No
Loss of use of extremity Yes / No

Hematology:
Bruise easily? Yes / No
Slow to Heal? Yes / No
Enlarged glands? Yes / No

Skin:
Rash? Yes / No
Itching? Yes / No
Change in hair/nails? Yes / No

Gastrointestinal:
Nausea? Yes / No
Vomiting? Yes / No
Abdominal pain? Yes / No
Rectal bleeding? Yes / No
Bowel problems? Yes / No

Allergy/Immunology:
Food Allergy? Yes / No
Other? Yes / No
(if yes, let provider know)

Psychiatric:
Insomnia? Yes / No
Confusion/Memory loss? Yes / No
Depression? Yes / No

Breast:
Nipple discharge? Yes / No
Breast pain? Yes / No
Breast lump? Yes / No

Women's Health:
Number of pregnancies? _____
Number of deliveries? _____
Age of 1st pregnancy? _____
How many years have you used birth Control or Hormone Replacement Therapy? _____
Did you breast feed? Yes / No
Menses started at what age?_____
What age did Menopause Begin? _____

Screening Dates:
When was your last:
Screening Mammogram _____
Screening Pap Smear _____
Screening Pelvic Exam_____
Screening EKG _____
Screening Colonoscopy_____
Last Eye Exam_____
By whom?_____

Vaccinations:
Date of last Pneumonia vaccine_____
Date of last Flu vaccine_____

Advanced Directives:
Do you have Advanced Directives in place? Yes / No
Does your doctor have a copy? Yes / No

I have reviewed this packet & I Attest to its validity:

Please initial	Date