

# Plotsky Medical Associates

## Medical Questionnaire

**NAME:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **REASON FOR TODAY'S VISIT:** \_\_\_\_\_

**AGE:** \_\_\_\_\_

**GENDER:** \_\_\_\_\_ **ETHNICITY/ORIGIN:** \_\_\_\_\_

**MEDICAL HISTORY: (check all that apply)**

- \_\_\_\_\_ High Blood Pressure
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Blood Disorder
- \_\_\_\_\_ Heart Attack
- \_\_\_\_\_ Stroke
- \_\_\_\_\_ Arthritis

- \_\_\_\_\_ Migraine Headaches
- \_\_\_\_\_ Intestinal Disorders
- \_\_\_\_\_ Gynecological Disorders
- \_\_\_\_\_ High Cholesterol
- \_\_\_\_\_ Cancer
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Other, Please Specify

**Specialists You See:**

- 1)
- 2)
- 3)
- 4)

**MEDICATION/FOOD ALLERGIES: Please list with reaction** **None**

\_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATIONS:**

Name	Dose	How Often	Reason for taking this medication

**SURGICAL HISTORY:**

Procedure	Date

**FAMILY HISTORY: (circle all that apply)**

	Alive (Y/N)	Heart Disease	Diabetes	Stroke	Cancer -Type	Other
Mother						
Father						
Siblings						
Other						

**SOCIAL HISTORY:**

Marital Status	Single	Married	Divorced	Widowed
Children	Yes/No	How Many		
Occupation				
Tobacco Use	Yes	No	Amount	
Alcohol	Yes	No	Amount	
Illegal Drugs	Yes	No	If yes: What and How Often	
Exercise	Yes	No	If yes: What and How Often	

**HEALTH MAINTENANCE:**

Procedure	Year of Last:
Pap Smear	
Mammogram	
Colonoscopy	
Bone Density	