Plotsky Medical Associates

Medical Questionnaire

NAME: _____ **TODAY'S DATE:** _____

DOB: _____ **REASON FOR TODAYS 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	