SOLID OAK ADULT AND PEDIATRIC CLINIC

MEDICAL HEALTH HISTORY QUESTIONNAIRE

Your answers on the form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important.

ALL QUESTIONS CONTAINED IN THE QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT CONFIDENTIAL.

Patient's Name:____ **D.O.B:**__________________

Please Check: ☐nternal Medicine ☐General Pediatrics ☐G.I. Patient

Main reason for today's visit: ____

Other concerns: ____

Please Check All That Apply: **PAST MEDICAL HISTORY**

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots (or DVT)	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes- Insulin	High Cholesterol	Stroke
Diabetes- Non-Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

PAST SURGICAL HISTORY

SURGERY	REASON & YEAR
1.	
2.	
3.	
4.	

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

SOCIAL HISTORY

1. __ Yes __ No Alcohol Consumption 2. __ Yes __ No Tobacco Consumption 3. __ Yes __ No Recreational Drugs

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Separated

Occupation: ____

MEDICATIONS

Please list all medication you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

PHARMACY NAME/LOCATION/PHONE #:____

Please add any additional information about your health that you would like your provider to know on the back of this form.