



Grand Traverse Internal and Family Medicine, P.C.

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Medical History Questionnaire

Date: _____ Date of Appointment: _____

Patient's Name: _____

Last

First

Middle

Address: _____ City _____ ST _____ ZIP _____

Home Phone: _____ Work Phone: _____ Mobile/Cell: _____

Date of Birth: _____ Email Address: _____

List all medications you are presently taking:

<i>Name of Medication & Dosage</i>	<i>Name of Medication & Dosage</i>

List any drug allergies or sensitivities:

List any previous immunizations and approximate date:

Past Medical History:

Has a doctor or other health care provider ever told you that you have any of the following?

High Blood Pressure

Diabetes

Coronary Artery Disease (Heart Disease)

Inflammatory bowel disease/Crohn's disease

Asthma

High Cholesterol

Diabetes only in pregnancy

Colon Cancer or polyps

Breast Cancer

HIV or AIDS

Are you currently receiving?

radiation therapy

chemotherapy

oral steroid medications



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Pregnancy Status: Pregnant Not Pregnant Chance of being pregnant

Date of last menstrual period? _____

List any surgeries and the year:

<i>Surgery</i>	<i>Year</i>

List diagnosis for any hospitalizations in past 10 years and the year hospitalized:

<i>Diagnosis</i>	<i>Year</i>

(If additional space is needed, please use the back of this form.)

Emotional Health:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	<i>Not at all</i>	<i>Several days</i>	<i>More than half the days</i>	<i>Nearly every day</i>
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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List any previous vaccinations and approximate date:

<i>Vaccine</i>		<i>Approximate Date</i>
Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumonia/Prevnar13	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Varicella (chicken pox)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gardasil (HPV)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Zostavax (shingles)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family History:

Member	Status	DOB	Age (yrs)	Conditions
Father				
Mother				
Son(s)				
Daughter(s)				
Brother(s)				
Sister(s)				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				

Do you have any specific questions for the doctor today? _____
