Grand Traverse Internal and Family Medicine, P.C.

David E. Oakley, M.D.
Charles R. Klettner, M.D.
Adrienne, B. Wagner, D.O. Family Medicine
Judith M. Yates, M.D.
Marci R. Bultemeier, D.O.
Elizabeth L. Hughes, D.O. Family Medicine
Mary Douglas, PA-C

Medical History Questionnaire

Date: _____ ***Date of Appointment:*** _____

Patient's Name: _____
Last *First* *Middle*

Address: _____ City _____ ST _____ ZIP _____

Home Phone: _____ Work Phone: _____ Cell: _____

Date of Birth: _____ Email Address: _____

List all medications you are presently taking:

Name of Medication & Dosage	***Name of Medication & Dosage***

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

Grand Traverse Internal and Family Medicine, P.C.

Pregnancy Status: ☐ Pregnant ☐ Not Pregnant ☐ Chance of being pregnant

Date of last menstrual period? _____

List any surgeries and the year:

Surgery	***Year***

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

Diagnosis	***Year***

(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?

	Not at all	*Several days*	*More than half the days*	*Nearly every day*
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

Grand Traverse Internal and Family Medicine, P.C.

Social History:

Tobacco:

☐ Current Smoker ☐ Every Day ☐ Some days but not every
Per Day: ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31+
Interested in quitting? ☐ Ready to quit ☐ Thinking about it ☐ Not ready
☐ Former Smoker
☐ Never Smoked

Alcohol:

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No
If yes, how often did you drink in the past year:
☐ Never ☐ Monthly or less ☐ 2-4x a month ☐ 2-3x a week ☐ 4+ times a week
If yes, how many drinks did you have on a typical day when you were drinking in the past year?
☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+
If yes, how often did you have 6 or more drinks on one occasion in the past year?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Sexual History:

Have you had sex in the last 12 months (vaginal, oral or anal)? ☐ Yes ☐ No
With: ☐ Men Only ☐ Women only ☐ Both Men and Women
Use protection? ☐ Yes ☐ No

Have you ever had a Sexually Transmitted Disease? ☐ Yes ☐ No

Chlamydia?	☐ Yes	☐ No
GC?	☐ Yes	☐ No
Syphilis?	☐ Yes	☐ No
Herpes?	☐ Yes	☐ No
Other?	☐ Yes	☐ No

Asthma History:

1. Do you have coughing, wheezing, shortness of breath or tightness in the chest during the day?
☐ Twice a week or less ☐ More than half the days
☐ Several days ☐ Nearly every day

Grand Traverse Internal and Family Medicine, P.C.

List any previous vaccinations and approximate date:

Vaccine		*Approximate Date*
Influenza	☐ Yes ☐ No	
Pneumonia/Prevnar13	☐ Yes ☐ No	
Tetanus	☐ Yes ☐ No	
Varicella (chicken pox)	☐ Yes ☐ No	
Gardasil (HPV)	☐ Yes ☐ No	
Zostavax (shingles)	☐ Yes ☐ 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? _____
_____
_____
_____
_____
_____