Internal Medicine & Geriatric Professionals
Medical Questionnaire New/ Transferring Patients

Name: _____ **Date:** _____

Medical History: List all illnesses you have or have had (HTN, Diabetes, high cholesterol, osteoporosis, cancer)

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

Surgical / Trauma History: List all operations and injuries you have had (gall bladder removal, bypass surgery, hysterectomy, hip fracture)

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

Do you have any **drug allergies**? Yes No
If yes, please list? _____

List all medicines, and dosages if known, which you take **daily**: (prescription and/or vitamins and supplements)

_____ _____

_____ _____

_____ _____

_____ _____

List any medications which you take on an occasional or **as needed** basis:

_____ _____

_____ _____

Social History:
Are you a smoker? Yes No
If so, how much _____ Daily or Weekly
How many years? _____
If not, have you previously been a smoker? Yes No
If so, when did you quit? _____

Do you drink **alcoholic beverages**? No Occasionally Regularly
If so, can you estimate how much per week you drink?
_____ Mixed drinks (1 ¼ oz) _____ Glasses of wine (6 oz.) _____ Beers (12 oz.)

Do you engage in routine **physical activity**? Yes No Occasional
If yes: _____ minutes of intense activity _____ times a week (running, aerobics)
_____ minutes of moderate activity _____ times a week (brisk walking, yoga)

What is your present weight? _____ lbs.
What is your usual weight? _____ lbs.

Please tell us about your medical **Family History:**

	Age	**Living**	**Deceased**	**Medical Problems**
Father				
Mother				
Siblings M/F				
M/F				
M/F				
M/F				
Children M/F				
M/F				
M/F				
M/F				

Who lives in your household? _____ I live alone _____ spouse or partner
Others: _____

Vaccinations: Please list date or approximate date of vaccinations below if you have received them.

Tetanus _____ Shingles Vaccine _____
Pneumovax® _____ Gardasil® _____
Influenza _____ Hepatitis B _____

Routine Screening: Please indicate of your have had any of the following screening tests. If so, please list approximate date. Listed screening recommendations assume no positive family history. Your personal recommended start date may be sooner.

	Never	Due	Approximate date	N/A
Cholesterol screen				
Diabetes screen				
Mammogram (females 40 +)				
Pap smear (females unless hysterectomy)				
Bone Density (postmenopausal)				
PSA (males only)				
Colonoscopy (50 and over)				