



Partners in Care

5616 Brainerd Rd Ste 108  
Chattanooga, TN 37411  
(P) 423.803.1379

**MEDICAL HISTORY QUESTIONNAIRE**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ E-Mail: \_\_\_\_\_

**Pharmacy**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Allergies:**

Allergy (Medication or food)	Reaction

**Past Medical History:** Please check all that apply

**Eye & Ear**

- Cataracts
- Macular degeneration
- Glaucoma
- Hearing loss/hearing aid

Other (specify) \_\_\_\_\_

**Heart**

- Heart attack, year \_\_\_\_\_
- Heart failure
- High blood pressure
- Heart valve problem
- High cholesterol
- Atrial Fibrillation
- Irregular heart beats
- Other (specify) \_\_\_\_\_

**Lungs**

- Asthma
- COPD/emphysema
- Recurrent pneumonias
- Other (specify) \_\_\_\_\_

**Gastrointestinal**

- Heartburn
- Ulcers
- Irritable Bowel
- Hepatitis
- Hemorrhoids
- Constipation
- Diverticulosis/it is
- Other (specify) \_\_\_\_\_



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#### Urinary

- Kidney Stones
- Frequent UTIs
- Urinary incontinence
- Enlarged Prostate
- Other (specify) \_\_\_\_\_

#### Bone & Joints

- Gout
- Osteoporosis
- Fibromyalgia
- Arthritis
- Hx of Fracture
- Other (specify) \_\_\_\_\_

#### Endocrine

- Diabetes
- Hypothyroidism
- Hyperthyroidism

- Other (specify) \_\_\_\_\_

#### Nervous System

- Dementia
- Parkinson's disease
- Stroke, year \_\_\_\_\_
- Epilepsy or seizures
- Essential Tremors
- Neuropathy
- Depression
- Anxiety
- Other (specify) \_\_\_\_\_

#### Other Health Problems

- Blood clot
- Anemia
- Cancer, what kind \_\_\_\_\_. Year diagnosed \_\_\_\_\_
- Autoimmune Disorders \_\_\_\_\_

#### Family Health History:

Have any members of your family had any of the following conditions? Check all that apply and indicate who had the condition including father, mother, brother, sister, maternal or paternal grandparents, children)

- Dementia Family Member \_\_\_\_\_
- Stroke Family Member \_\_\_\_\_
- Diabetes Family Member \_\_\_\_\_
- Depression Family Member \_\_\_\_\_
- Heart disease Family Member \_\_\_\_\_
- High Blood Pressure Family Member \_\_\_\_\_
- High Cholesterol Family Member \_\_\_\_\_
- Cancer:
  - Breast Family Member \_\_\_\_\_
  - Prostate Family Member \_\_\_\_\_
  - Colon / Rectum Family Member \_\_\_\_\_
  - Lung Family Member \_\_\_\_\_
  - Skin Family Member \_\_\_\_\_
  - Lymphatic Family Member \_\_\_\_\_
- Other (specify): \_\_\_\_\_ Family Member \_\_\_\_\_



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**Medication List:** (including supplements)

Drug	Strength	How many times a day do you take it?

**Your Specialists:**

Specialty	Name
Family Practice	_____
Cardiology	_____
Pulmonology	_____
Gastroenterology	_____
Endocrinology	_____
Rheumatology	_____
Hematology/Oncology	_____
Allergy	_____
Dermatology	_____
Nephrology	_____
Neurology	_____
Ophthalmology	_____
Psychiatry	_____



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- Urology \_\_\_\_\_
- Podiatry \_\_\_\_\_
- Orthopedics \_\_\_\_\_
- Gynecology \_\_\_\_\_

**Surgeries:**

Please list all operations you have ever had, and the year (or your age) when performed.

- Pacemaker insertion \_\_\_\_\_
- Coronary Artery Bypass Surgery \_\_\_\_\_
- Angioplasty or Stent \_\_\_\_\_
- Appendectomy \_\_\_\_\_
- Cholecystectomy (gallbladder removal) \_\_\_\_\_
- Hysterectomy (partial or total ) \_\_\_\_\_
- Cataract removal and year done: R eye \_\_\_\_\_ L eye \_\_\_\_\_
- Hip or knee replacement \_\_\_\_\_
- Orthopedic Surgery \_\_\_\_\_
- Hernia repair \_\_\_\_\_
- Mastectomy \_\_\_\_\_
- Tonsillectomy \_\_\_\_\_
- Any other surgeries:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Procedures:**

If you have ever had any of the following procedures or tests, please give year, location, and results

- Upper endoscopy or EGD: \_\_\_\_\_
- Stress test \_\_\_\_\_
- Cardiac catheterization \_\_\_\_\_
- Echocardiogram \_\_\_\_\_
- CT scan or MRI scans \_\_\_\_\_
- Chest X-ray \_\_\_\_\_

**Woman Screenings (date):**

- Last Pap Test \_\_\_\_\_
- Mammogram \_\_\_\_\_
- Bone Density \_\_\_\_\_
- Colonoscopy \_\_\_\_\_

- Eye Exam \_\_\_\_\_

**Men Screenings (date):**

- Colonoscopy \_\_\_\_\_
- PSA Screening \_\_\_\_\_
- Eye Exam \_\_\_\_\_



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#### **Vaccines (date):**

- Tetanus \_\_\_\_\_
- Shingles \_\_\_\_\_
- Pneumonia \_\_\_\_\_
- Influenza \_\_\_\_\_
- COVID-19 \_\_\_\_\_

#### **Social History**

How much school did you complete?

- Less than 8th grade
- Some high school
- High school graduate
- Some college
- College graduate
- Graduate school

You are presently (check one):

- Not working
- Working, where \_\_\_\_\_
- Retired, Previous occupation \_\_\_\_\_
- Disabled, since (year) \_\_\_\_\_

How many children do you have? Number: \_\_\_\_\_

Do you have a Power of Attorney for Healthcare? If so, who is it \_\_\_\_\_ . Phone number \_\_\_\_\_

#### **Tobacco Use:**

Have you ever smoked or chewed tobacco products?

- Yes
- No

If you answered no above, please proceed to the section below on alcohol use.

Are you a currently a cigarette smoker?

- Yes
- No

How many cigarettes are you smoking? \_\_\_\_\_

If you are a former cigarette smoker, what year did you quit? \_\_\_\_\_

With whom do you live?

- Alone
- Spouse or Partner
- Child
- Other (specify): \_\_\_\_\_

What is your marital status?

- Single/Never married
- Married
- Divorced/Separated
- Widowed
- Living with significant other

For how many years did you smoke cigarettes?  
\_\_\_\_\_.

How many packs per day, on average? \_\_\_\_\_

#### **Alcohol Use:**

Do you currently drink alcoholic beverages (beer, wine or liquor)?

- Yes
- No

If yes, how many drinks per week, on average?  
\_\_\_\_\_.

At any time in your life, were you an alcoholic or heavy drinker?

- Yes
- No



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#### **Depression Screening:**

Over the past two weeks, how often have you been bothered by any of the following problems:

Little interest or pleasure in doing things

- Not at all
- Several days
- More than half the days
- Nearly every Day

Feeling down, depressed, or hopeless

- Not at all
- Several Days
- More than half the days
- Nearly every day

Any history of suicide attempts

- Yes
- No

#### **Childhood Experience Questionnaire:**

**While you were growing up, during your first 18 years of life:**

Did a parent or other adult in the household often swear at you, insult you, put you down or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

- Yes
- No

Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

- Yes
- No

Did a parent or adult in the household often push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

- Yes
- No

Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

- Yes
- No

Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you?

- Yes
- No

Was a household member depressed or mentally ill or did a household member attempt suicide?

- Yes
- No

Did a household member go to prison?

- Yes
- No

Did you often feel no one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

- Yes
- No

Did you often feel that you didn't have enough to eat, had to wear dirt clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

- Yes
- No

Were your parents ever separated or divorced?

- Yes
- No