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 _____

Partners in Care

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

MEDICAL HISTORY QUESTIONNAIRE

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 _____

Partners in Care

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

MEDICAL HISTORY QUESTIONNAIRE

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	

Partners in Care

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

MEDICAL HISTORY QUESTIONNAIRE

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 _____

Partners in Care

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

MEDICAL HISTORY QUESTIONNAIRE

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) _____

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

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 may cigarettes are you smoking? _____

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

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

Partners in Care

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

MEDICAL HISTORY QUESTIONNAIRE

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

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 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

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

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