Donni Fleischaker
PRIMARY CARE & PEDIATRICS

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Medical History Questionnaire

Please complete this form and bring it to your appointment. Print clearly.

PATIENT FULL NAME _____ DATE OF BIRTH _____ TODAY'S DATE _____

PRIMARY CARE REASON / MAIN CONCERN TODAY _____ PREVIOUS DOCTOR / CLINIC _____

ALLERGIES

MEDICATION, FOOD OR ENVIRONMENTAL ALLERGIES & REACTIONS (WRITE "NONE" IF NONE)

CURRENT MEDICATIONS

List prescription & over-the-counter medicines, vitamins and supplements, with dose and how often.

PAST MEDICAL HISTORY — CHECK ALL THAT APPLY

- ☐ Asthma
- ☐ Allergies / hay fever
- ☐ High blood pressure
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Thyroid disorder
- ☐ Cancer
- ☐ Depression / anxiety
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Seizures
- ☐ Stroke
- ☐ GERD / acid reflux
- ☐ Arthritis
- ☐ Migraines
- ☐ COPD / lung disease
- ☐ Blood clots

OTHER CONDITIONS

PAST SURGERIES & HOSPITALIZATIONS

PROCEDURE & YEAR _____ PROCEDURE & YEAR _____

FAMILY HISTORY

Note conditions in parents, siblings or grandparents (e.g., diabetes, heart disease, cancer).

SOCIAL HISTORY

TOBACCO USE

☐ Never ☐ Former ☐ Current

ALCOHOL USE

☐ None ☐ Occasional ☐ Regular

EXERCISE

☐ Rarely ☐ 1–2×/wk ☐ 3+×/wk

PATIENT / GUARDIAN SIGNATURE _____ DATE _____