Harvard Family Physicians, P.C.
Family Medicine OB / GYN Pediatrics Chiropractic
Physical Therapy Pharmacy

Medical Questionnaire

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DATE:______________________________

NAME:______________________________ DOB:________________ AGE:________ SEX: ________

MARITAL STATUS:______________ # OF CHILDREN:__________ OCCUPATION:______________________

RACE:______________________ PREFERRED PHARMACY LOCATION:______________________

Past Medical History: (check any of the following which you have or been treated for)

❒ High Blood Pressure ❒ Cardiac Disease ❒ Diabetes ❒ Cancer
❒ Liver Disease ❒ Kidney Disease ❒ Asthma/Emphysema ❒ Stomach Trouble
❒ Neurological Disorder (Stroke, etc) ❒ Arthritis (Joint Problems) ❒ Other______________________

Surgical Procedures	Year and Where	Hospitalizations	Year and Where

Regular Medications: **(including dosage and frequency; include prescription, over-the-counter, vitamins, birth control pills, etc.)**

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

ALLERGIES TO MEDICATIONS ____________ ____________ ____________
OTHER ALLERGIES ____________ ____________ ____________

Family History: (check all that apply)	Relation	Age it Occurred
❒ Hypertension		
❒ Heart attack		
❒ Strokes		
❒ Diabetes		
❒ Ovarian Cancer		
❒ Breast Cancer		
❒ Colon Cancer		
❒ Other Cancer		
❒ Tuberculosis		
❒ Glaucoma		
❒ Neurological Disorder		

Social History:

Cigarettes:________________packs/day for ______________years. Date Quit?____________
Alcoholic drinks:__________drinks per____________day. Date Quit?______________________
Coffee:______________cups/day; pop/tea:____________glasses/day
Exercise type:____day/week________________
Hobbies:____

Birth:	**Name of Children**	**Age**
# of pregnancies?________________		
# of miscarriages________________		
# of c/sections________________		
# of vaginal________________		

Peripheral Arterial Disease (PAD):

❒ Leg Pain while Walking ❒ Leg Muscle Discomfort ❒ Calf Pain
❒ Leg Numbness or Weakness ❒ Cold Feet or Legs ❒ Sores on Toes
❒ Feet or Leg Sores that will not Heal

(Continued on back)

Review of Systems: (check if you have or have had any of the following)

GENERAL

_________ recent weight loss or gain (Please Circle One)
_________ fevers or nights sweats (Please Circle One)
_________ mood disturbance (i.e. depression, anxiety, etc.)
_________ fatigue
_________ last tetanus shot
_________ last flu shot

HEAD/NEUROLOGIC

_________ headache
_________ dizziness
_________ fainting
_________ paralysis or weakness of limbs (Please Circle One)
_________ numbness
_________ tremor or shakes
_________ poor coordination
_________ difficulty in speech
_________ history of head injury

ENT

_________ seeing double
_________ dark spots
_________ flashing lights before your eyes
_________ recent change in eyesight
_________ cataracts
_________ hearing loss
_________ ringing in the ears
_________ nose bleed
_________ hay fever or nasal congestion (Please Circle One)
_________ sinus infection
_________ sores in mouth
_________ frequent sore throats
_________ difficulty swallowing
_________ hoarseness or voice change (Please Circle One)

NECK

_________ pain or stiffness in the neck (Please Circle One)
_________ fullness in the neck or throat

HEART and LUNGS

_________ heart attack
_________ angina or chest pain
_________ congestive heart failure
_________ difficulty breathing
_________ emphysema or chronic bronchitis
_________ asthma or wheezing
_________ cough
_________ irregular or rapid heart beat
_________ swelling (edema)
_________ murmurs
_________ mitral valve prolapse

SKIN/HAIR

_________ rashes
_________ sores
_________ lumps
_________ skin cancers
_________ hair loss
_________ itching

STOMACH and BOWELS

_________ nausea/vomiting
_________ indigestion, belching, or excess gas
_________ food intolerance
_________ bloating or abdominal distension
_________ abdominal pain
_________ jaundice or yellow discoloration
_________ diarrhea or constipation
_________ bloody or black stools

GENITOURINARY

_________ increased frequency of urination
_________ urinary urgency
_________ getting up at night to urinate - # of time ________
_________ history of urinary infections
_________ blood in the urine
_________ difficulty urinating or burning or urination
_________ leakage of dribbling of urine
_________ history of venereal disease
_________ lumps in genital area
_________ kidney stones
_________ prostate problems
_________ sexual difficulties

MENSTRUAL

_________ interval between menstrual periods
_________ duration of flow
_________ any chance of pregnancy at this time
_________ vaginal discharge
_________ vaginal or pelvic discomfort
_________ pain during intercourse
_________ date of last menstrual period
_________ date of last pap
_________ method of birth control
_________ mammogram date ___________________________

MUSCLES, BONES, and JOINTS

_________ joint pain or stiffness
_________ joint swelling or redness
_________ backache
_________ muscle aches
_________ decreased muscle strength

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Physician Signature **Date**