HATTIESBURG CLINIC

415 S. 28th Avenue · Hattiesburg, MS 39401

Name: _____

Date of Birth: _____

History #: _____

Physician: _____

LABEL

MEDICAL HISTORY QUESTIONNAIRE

Information to Become Part of Your Confidential Medical Records

Side I

PLEASE PRINT

First	Middle	Last	Age:	Sex:	Religion:
NAME:					

MARTIAL STATUS (✓)	EDUCATION (Years Completed)	
☐Single ☐ Widowed	☐Grade	Business or ☐Vocational
☐Married ☐ Divorced	☐High	☐College
☐Separated		

PREVIOUS PHYSICIAN:

TYPE OF WORK OR OCCUPATION:

(✓) CHECK REASON FOR SEEKING MEDICAL CARE?		Describe below problems you wish to discuss with doctor today:
☐Illness / Personal Reasons	☐Company Physical	1. _____
☐Routine / Annual Exam	☐Insurance Exam	2. _____
☐Job Related Injury	☐Pre-employment Exam	3. _____
☐Other *(Describe)*		4. _____

FAMILY HISTORY

Parents	Age if Living	Age at Death	Present Condition or Cause of Death?
Father			
Mother			

Number of Brothers _____

Number of Sisters _____

Children _____ Number Ages

Number Living In Your Household? _____

Has anyone in your immediate family (Father, Mother, Brothers or Sisters) had any of the medical problems listed below? *If yes, Who?*

☐Cancer _____
☐Ulcers _____
☐Allergy _____
☐Diabetes _____
☐Asthma _____
☐Tuberculosis _____
☐Thyroid Trouble _____
☐Suicide _____
☐Mental Illness _____
☐Stroke _____
☐Heart Trouble _____
☐High Blood Pressure _____
☐Bleeding Tendency _____
☐Other *(Describe)* _____

WEIGHT HISTORY

Present Weight _____lbs.

Usual Weight _____lbs.

Weight Changes During Past Year?

Gained _____lbs.

Lost _____lbs.

How Many Meals Do You Eat Daily?

_____ Meals

HABIT HISTORY

SMOKING:

Pipe _____ Packs per Day ____

Cigar _____ No. of Years _____

Chew _____ Year Stopped _____

ALCOHOL:

Never _____ Occasional _____

Moderate _____ Heavy _____

COFFEE:

Cups per Day _____

(✓) Check Known Allergies or Reaction to Medications Below. *(List Any Not Shown)*

	Penicillin
	Sulfa
	Antibiotics
	Sedatives
	X-Ray / Dyes

LIST MEDICATIONS / DRUGS TAKEN OVER PAST 6 MONTHS

Medications / Drugs	Reason Taken	How Long Taken?	Stop Taking?

WHICH DRUGS DO YOU TAKE?

☐Aspirin ☐Antacids
☐Tranquilizers ☐Vitamins
☐Birth Control Pills ☐Laxatives
☐"Hormones"

PLEASE INDICATE PREVIOUS MAJOR ILLNESSES, SURGERY OR INJURY

Define Problem	Where Did it Happen?	Year	Difficulties Now?

(✓) CHECK ANY ITEMS BELOW WHICH YOU ARE EXPOSED TO BY BREATHING OR SKIN CONTACT

☐Chemicals _____
☐Dust _____
☐Toxins _____
☐Fumes _____
☐Sprays _____
☐Insecticides _____
☐Other *(Explain)* _____

SIDE II

PAST HISTORY : (✓) CHECK BELOW ANY PROBLEMS YOU HAVE NOW – OR THAT YOU HAVE HAD IN THE PAST.		
☐ASTHMA	☐CIRRHOSIS	☐DIABETES
☐PNEUMONIA	☐HEPATITIS	☐KIDNEY STONE
☐TUBERCULOSIS	☐ULCERS	☐VENEREAL DISEASE
☐HEART TROUBLE	☐PANCREATITIS	☐MUMPS / MEASLES
☐RHEUMATIC FEVER	☐GALLBLADDER PROBLEMS	☐POLIO / MENINGITIS

	SYSTEM REVIEW: (✓) CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR FINDINGS.		
GENERAL	☐SKIN RASH ☐LETHARGY / WEAKNESS ☐LOSS OF INTEREST IN EATING ☐ALWAYS HUNGRY ☐TEND TO BE HOT OR COLD ☐CHILLS / NIGHTS SWEATS ☐SLEEPING DIFFICULTIES	**GI**	☐HEART BURN OR INDIGESTION ☐BELCHING OR NAUSEA ☐JAUNDICE ☐DIFFICULTY SWALLOWING ☐STOMACH PAINS ☐VOMITING BLOOD ☐CONSTIPATION ☐RECENT CHANGE IN BOWEL HABITS ☐LOOSE BOWELS / DIARRHEA ☐BLACK OR BLOODY STOOLS ☐PAIN IN RECTUM ☐HEMORRHOIDS ☐AMOEBA / PARASITES
HEAD	☐FREQUENT HEADACHES ☐DIZZY SPELLS ☐FAINTING SPELLS / UNCONSCIOUSNESS		
EYES	☐WEAR GLASSES ☐EYESIGHT WORSENING ☐DOUBLE VISION ☐EYE PAINS OR ITCHING	**GU**	☐FREQUENT NIGHT OR DAY VOIDING ☐BURNING ON URINATION ☐PUS OR BLOOD IN URINE ☐DIFFICULTY STARTING URINE ☐DRIBBLING WITH COUGHING / SNEEZING ☐OTHER KIDNEY DISEASE ☐SEX DIFFICULTIES
EARS	☐DEAFNESS ☐EARACHES OR DRAINAGE ☐NOISE IN EARS		
NOSE	☐CONGESTION / SNEEZING ☐SINUS TROUBLE / HAY FEVER ☐NOSE BLEED	**NERVOUS**	☐CONVULSIONS / SEIZURES ☐STROKE / PARALYSIS ☐DIFFICULTY MAKING DECISIONS ☐MEMORY PROBLEMS ☐CRY OFTEN / DEPRESSED / FEEL SAD ☐WORRY A LOT ☐CONSIDERED SUICIDE
THROAT	☐SORE THROAT OR TONGUE ☐HOARSE VOICE ☐DENTAL PROBLEMS ☐GOITER / THYROID TROUBLE ☐NECK PAINS OR LUMPS		
LUNG AND HEART	☐WHEEZING / COUGHING SPELLS ☐COUGH UP PHLEGM ☐SHORTNESS OF BREATH ☐EMPHYSEMA ☐COUGH UP BLOOD ☐EXPOSED TO TB ☐HEART RACING / PALPITATIONS ☐HIGH BLOOD PRESSURE ☐SWOLLEN FEET OR ANKLES ☐CHEST PAINS ☐HEART ATTACK ☐HEART MURMUR	**MISCELLANEOUS**	☐BLEED / BRUISE EASILY ☐ANEMIA / LOW BLOOD ☐BLOOD DISEASE ☐ENLARGED GLANDS / NODES ☐ACHING MUSCLES / JOINTS ☐VARICOSE VEINS ☐LEG CRAMPS / PAINS ☐PAINFUL FEET ☐CANCER ☐PROLONGED FEVER ☐OTHER _____

MEN ONLY			MEN ONLY
	☐WEAK URIN STREAM ☐PROSTATE TROUBLE ☐LUMP ON TESTICLES	☐IMPOTENCE ☐CHANGE IN SEX DESIRE ☐BURNING OR DISCHARGE	

WOMEN ONLY	(✓) CHECK IF YOU HAVE HAD OR COMPLETE AS REQUESTED THE ITEMS INDICATED BELOW							WOMEN ONLY
	☐Ceasarean Sec. ☐Hysterectomy	☐Toxemia ☐Lumps in Breasts	Number of Pregnancies _____	Number of Miscarriages _____	Date of Last Pap Smear _____/_____	Date Menstruated Last_____	Any Menstrual Problems? _____	

Please Ask Physician for Your Service Ticket Following Exam.

CLINIC
PHYSICIAN'S
SIGNATURE_____M.D.