Medical History Questionnaire

MEMORIAL HEALTH CARDIOVASCULAR & THORACIC SURGERY

Name: _____ Date of Birth: _____

Past or Current Personal Medical History (Check all that apply)

_____ Diabetes
_____ Asthma
_____ Cancer
_____ Congestive heart disease
_____ COPD
_____ Heart attack
_____ Alzheimer's disease
_____ Stroke
_____ High blood pressure
_____ High cholesterol
_____ Thyroid issues
_____ Seizures
_____ Blood clots
_____ Arthritis/osteoporosis
_____ Stomach/bowel problems
_____ Migraines
_____ Depression/anxiety
_____ Hep B/Hep C/HIV

Other illness or conditions not listed above: _____

Family History (Circle all that apply)

Mother: Diabetes High blood pressure Heat disease Stroke Cancer Other:_____
Father: Diabetes High blood pressure Heart disease Stroke Cancer Other:_____
Grandparents: Diabetes High blood pressure Heart disease Stroke Cancer Other:_____
Siblings: Diabetes High blood pressure Heat disease Stroke Cancer Other:_____

Past Procedures and Surgeries

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Social History

Do you smoke? ☐ Yes ☐ No
If no, are you a previous smoker? ☐ Yes ☐ No Quite date: _____
Do you drink alcohol? ☐ Yes ☐ No Do you use illicit drugs? ☐ Yes ☐ No

Medications Currently Taking (please list name, dose, and frequency)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Medication Allergies

1. _____ 2. _____ 3. _____ 4. _____