Hilton Health Care, P. C.

SHORT MEDICAL HISTORY QUESTIONNAIRE

Name: _____ DOB _____ Date _____
Occupation: _____

List all medications you currently take (include Vitamins and Supplements) Use backside if needed

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have allergies to medications? Y/N If yes please specify _____
_____
List any major illnesses or injuries: _____
_____
List any major surgeries: _____
Do you smoke? Y/N How much? _____ When did you start: _____
Are you having any issues today? _____

General Issues (if yes, please explain)		**Explanation**
Ears, Nose, and Throat	Y/N	_____
Cardiovascular (Heart, BP, Stroke, etc.)	Y/N	_____
Respiratory (Asthma, Emphysema, etc.)	Y/N	_____
Gastrointestinal (Stomach, Ulcers, etc.)	Y/N	_____
Genital, Kidney, Bladder	Y/N	_____
Muscles, Bones, Joints (Arthritis, etc.)	Y/N	_____
Skin (Acne, Warts, Skin Cancer, etc.)	Y/N	_____
Neurological (Multiple Sclerosis, Headaches, Seizures, etc.)	Y/N	_____
Endocrine (Diabetes, Thyroid, etc.)	Y/N	_____
Blood, Lymph (High Cholesterol, Anemia, etc.)	Y/N	_____
Allergic, Immunologic (Hay Fever, Lupus, etc.)	Y/N	_____
General Health (Fever, Weight Gain/Loss, Unusually Tired, etc.)	Y/N	_____
Psychiatric (Depression, Anxiety, etc.)	Y/N	_____

Significant Family History (Parents, Siblings, Grandparents)

Diabetes	Y/N	Hypertension	Y/N	Heart Disease	Y/N
Cancer	Y/N	Strokes	Y/N	Mental Illness	Y/N

_____ _____
Signature Date