BETH ISRAEL DEACONESS HOSPITAL - MILTON

MEDICAL QUESTIONNAIRE

The purpose of this questionnaire is to assist us in providing you with quality care by obtaining a better understanding of your total health status. This questionnaire is part of you confidential medical record.

Date of Next M.D. visit: _____

Medications: Please list **ALL** medications currently being taken (include over the counter supplements and herbal medications), along with dosage, if known, and frequency:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Surgeries: Please list **ALL** surgeries and approximate dates.

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Abuse/Neglect Screening: Please read the following statement and check appropriate answer. Because violence is so common in many people's lives, we have begun to ask all of our patients about it. Is there anything you are concerned about related to your safety and wellbeing at home or in the community? Please check ☐ Yes ☐ No

Other Past Medical and Family History: (i.e., sprains, ulcers, etc.) _____

_____

At the present time, would you say your health is: ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Lifestyle: ☐ Non Smoker ☐ Smoker _____ packs / day
☐ No Alcohol ☐ Alcohol _____ drinks / day
☐ No Exercise ☐ Exercise _____ times / day

Family History: _____

Patient Signature: _____ **Date:** _____ **Time:** _____

Therapist Signature: _____ **Date:** _____ **Time:** _____

☐ Reeval review Pt. initial _____ Date _____ ☐ Reeval review Pt. initial _____ Date _____
Time: _____

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Do you have, or have you had any of the following: Please check all that apply.

- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Heart Palpitations
- ☐ Chest Pain
- ☐ Asthma
- ☐ Difficulty Sleeping Flat
- ☐ Ulcers
- ☐ Nausea, Vomiting
- ☐ Weight Loss / Weight Gain in the Last Month
- ☐ Currently Pregnant
- ☐ Abnormal or Painful Menstruation
- ☐ Blood in Urine
- ☐ Bladder / Kidney Infection
- ☐ Major Dental Work
- ☐ Seizures/Head Trauma
- ☐ Paralysis
- ☐ Loss of Consciousness
- ☐ Headaches
- ☐ Muscle Cramps
- ☐ Falls within last 6 months
- ☐ Hot or Cold Intolerance
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Shortness of Breath
- ☐ Cancer/Tumors
- ☐ Night Sweats
- ☐ Bleeding, Bruising
- ☐ Rashes
- ☐ Stroke
- ☐ Blurred or Double Vision
- ☐ Incontinence
- ☐ Difficulty Eating
- ☐ Psychiatric/Psychological Care
- ☐ Numbness or Tingling
- ☐ Balance Problems/Dizziness

Allergies: _____

Patient Signature: _____ **Date:** _____ **Time:** _____

Therapist Signature: _____ **Date:** _____ **Time:** _____