Medical History Questionnaire

1. Name ____ 2. Today's Date __________________

3. Your chief medical problem *(the reason for your coming to the Lahey Clinic):*

____

4. Names of all drugs or medicines you are now taking (mci. aspirin, laxatives, antacids):

____

____

5. Drugs or medicines to which you have a bad or allergic reaction: ________________________________

6. Have you been exposed to radiation (other than diagnostic x-rays)? ______________________________

7. Immunizations — indicate date you were last immunized against: tetanus __________ influenza ___________

pneumonia __________ Other: ____

8. List all hospitalizations, operations, injuries:

(Women: Do not list normal pregnancies)

Year	**Reason**	**Hospital**

9. Check off any of the following tests you have had; give approximate month and year they were last done:

Date	**Test**
______________	**Chest x-ray**
______________	**Kidney x-ray (IVP)**
______________	**Upper GI series**
______________	**Barium ene**
______________	**Gallbldder x-ray**
______________	**Chest x-ray**
______________	**Eye examination**

10. Have you ever been turned down for life insurance, military service or employment for health problems? yes no

11. Place an (x) before any illness you have had. State year you first learned of it if possible.

___ heart murmur
___ rheumatic fever
___ heart attack or angina pectoris
___ other heart disease
___ high blood pressure
___ blood transfusion
___ pneumonia, pleurisy

___ emphysema
___ allergies (hay fever, hives, asthma)
___ anemia
___ bleeding disorder
___ jaundice hepatitis
___ ulcer (peptic, duodenal, gastric)

___ arthritis
___ diabetes
___ phlebitis
___ thyroid trouble
___ venereal disease
___ tumor
___ cancer

___ nervous disorder
___ glaucoma
___ albuminuria, protein urine
___ kidney stones
___ kidney or bladder trouble
___ epilepsy
___ tuberculosis

Other illness (specify): ____

____

12. Do you smoke? yes no

Estimate amount: _________

13. Do you use alcoholic beverages? yes no

Estimate amount: _________