

LAMPREY HEALTH CARE

Medical History Questionnaire

NAME: _____ D.O.B.: _____ DATE: _____

What hospitalizations/operations have you had? _____

For what conditions do you see the doctor more than once a year? _____

What medicines do you take more than once a month (including Aspirin, Tylenol, laxatives, birth control pills, vitamins, etc.)? _____

Please check the boxes below that fit your family medical history to the best of your knowledge.

	Myself	Mother	Father	Sister	Brother	Mother's side	Father's side	Child	Other Family	None		Myself	Mother	Father	Sister	Brother	Mother's side	Father's side	Child	Other Family	None	
High Blood Pressure											Liver Disease/ Hepatitis											
Heart Problem (before age 50 yrs)											Cirrhosis											
Heart Problem (after age 50 yrs)											Stroke											
Colon/Rectal Cancer											Diabetes											
Anxiety/Panic Attacks											High Cholesterol											
Depression											Smoking											
Alzheimer's Disease											Eating Disorder											
Other Mental Illness											Alcohol Abuse											
Arthritis (Type _____)											Drug Abuse											
Birth Defects											Asthma											
Hereditary Conditions											Allergies/ Hayfever											
Seizure/Epilepsy											Kidney Failure											
Migraine Headaches											Breast Cancer											
Hearing Loss (before age 50 yrs)											Cancer (other type)											

FOR LAMPREY HEALTH CARE USE ONLY

Reviewed by: _____ Date: _____