

eXclusive Services

**11134 Lushek Drive
Cincinnati, OH 45241
Office: (513) 827-9273
Fax: (513) 818-9960
treatment@xservices.org**

MEDICAL HISTORY QUESTIONNAIRE

This is your medical history form, to be completed prior to commencing treatment at eXclusive Services. All information will be kept confidential. This form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out.

If you have questions or concerns, we will help you with those after this form is completed. If some parts of the form are unclear to you, do your best to complete the form, and your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Name: _____

Date: ____/____/____

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MEDICAL HISTORY AND SCREENING FORM

(AoD, MAT, MH)

General Information

Participant:

Name _____

Address _____

Contact phone numbers _____

Birth date _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ City _____

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

Yes No

Signature: _____

Marital Status:

Single Married Divorced Widowed

Sex:

Male Female

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- Has a doctor ever said your blood pressure was too high?
- Do you ever have pain in your chest or heart?
- Are you often bothered by a thumping of the heart?
- Does your heart often race?
- Do you ever notice extra heartbeats or skipped beats?

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- Are your ankles often badly swollen?
- Do cold hands or feet trouble you even in hot weather?
- Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- Do you suffer from frequent cramps in your legs?
- Do you often have difficulty breathing?
- Do you get out of breath long before anyone else?
- Do you sometimes get out of breath when sitting still or sleeping?
- Has a doctor ever told you your cholesterol level was high?
- Has a doctor ever told you that you have an abdominal aortic aneurysm?**
- Has a doctor ever told you that you have critical aortic stenosis?**

Comments: _____

Do you now have or have you recently experienced:

- Chronic, recurrent or morning cough?
- Episode of coughing up blood?
- Increased anxiety or depression?
- Problems with recurrent fatigue, trouble sleeping or increased irritability?
- Migraine or recurrent headaches?
- Swollen or painful knees or ankles?
- Swollen, stiff or painful joints?
- Pain in your legs after walking short distances?
- Foot problems?
- Back problems?
- Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
- Significant vision or hearing problems?
- Recent change in a wart or a mole?
- Glaucoma or increased pressure in the eyes?
- Exposure to loud noises for long periods?
- An infection such as pneumonia accompanied by a fever?
- Significant unexplained weight loss?
- A fever, which can cause dehydration and rapid heart beat?
- A deep vein thrombosis (blood clot)?
- A hernia that is causing symptoms?
- Foot or ankle sores that won't heal?
- Persistent pain or problems walking after you have fallen?

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List any other medical or diagnostic test you have had in the past two years: _____

List hospitalizations, including dates of and reasons for hospitalization: _____

List any drug allergies: _____

Past Medical History

Check those questions to which your answer is yes (leave others blank).

- Heart attack if so, how many years ago? _____
- Rheumatic Fever
- Heart murmur
- Diseases of the arteries
- Varicose veins
- Arthritis of legs or arms
- Diabetes or abnormal blood-sugar tests
- Phlebitis (inflammation of a vein)
- Dizziness or fainting spells
- Epilepsy or seizures
- Stroke
- Diphtheria
- Scarlet Fever
- Infectious mononucleosis
- Nervous or emotional problems
- Anemia
- Thyroid problems
- Pneumonia
- Bronchitis
- Asthma
- Abnormal chest X-ray
- Other lung disease
- Injuries to back, arms, legs or joint
- Broken bones
- Jaundice or gall bladder problems

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Comments: _____

Family Medical History

Father:

Alive Current age _____

My father's general health is:

Excellent Good Fair Poor

Reason for poor health: _____

Deceased Age at death _____

Cause of death: _____

Mother:

Alive Current age _____

My mother's general health is:

Excellent Good Fair Poor

Reason for poor health: _____

Deceased Age at death _____

Cause of death: _____

Siblings:

Number of brothers _____ Number of sisters _____ Age range _____

Health problems _____

Familial Diseases

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave other blank).

Heart attacks under age 50

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- Strokes under age 50
- High blood pressure
- Elevated cholesterol
- Diabetes
- Asthma or hay fever
- Congenital heart disease (existing at birth but not hereditary)
- Heart operations
- Glaucoma
- Obesity (20 or more pounds overweight)
- Leukemia or cancer under age 60

Comments: _____

Other Heart Disease Risk Factors

Smoking

Have you ever smoked cigarettes, cigars or a pipe?

- Yes No

(If no, skip to diet section)

If you did or now smoke cigarettes, how many per day? _____ Age started _____

If you did or now smoke cigars, how many per day? _____ Age started _____

If you did or now smoke a pipe, how many pipefuls a day? _____ Age started _____

If you have stopped smoking, when was it? _____

If you now smoke, how long ago did you start? _____

Comments: _____

