**eXclusive Services**
**11134 Luschek 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 be 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

## General Information

### Participant:

Name _____

Address _____

Contact phone numbers _____

Birth date _____

### Previous Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ City _____

May I obtain previous records from your former health care provider and consult with them as necessary?

☐ Yes ☐ No

What was the date of your last exam/visit? ____/____/____

Signature: _____ Date: ____/____/_____

### Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

### Sex:

☐ Male ☐ Female

### 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?

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- ☐ 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?
- ☐ Eye conditions such as bleeding in the retina or detached retina?
- ☐ Cataract or lens transplant?
- ☐ Laser treatment or other eye surgery?

**Comments:** _____
_____
_____
_____

## Regarding your last physical exam:

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last chest X-ray:_____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last electrocardiogram (EKG or ECG): _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last dental check up: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

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

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

List any drug allergies: _____
_____
_____

## 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)?

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

- ☐ Heart attacks under age 50
- ☐ 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:** _____

_____

_____

_____