FERRUCCI, FERRUCCI & MORRIS **MEDICAL QUESTIONAIRE**

PATIENT'S NAME: **DOB:**

Reason for this Visit: ☐ANNUAL ☐OTHER please explain

ALLERGIES Do You Have Any Allergies to any Medication, X-ray Dyes, or other substanses? ☐NO
☐YES if yes, please list the substance or medication and the reaction

MEDICAL HISTORY Please check if you have any of the following medical conditions

☐High Blood Pressure
☐Heart Disease
☐Asthma
☐Colon or bowel disease
☐Thyroid disease
☐Kidney disease or Kidney stones
☐Skin diseases
☐Anemia
☐Other: please list below

☐Diabetes
☐Mitral Valve Prolapse
☐TB other lung disease
☐Gall Bladder disease
☐Arthritis
☐Epilepsy or seizures
☐Blood Disorders
☐Alcohol problems

☐Cancer
☐Heart Murmur
☐Ulcers
☐Hepatitis,cirrhosis,Jaundice
☐HIV or AIDS
☐Osteoporosis
☐Depression
☐Drug problems

MEDICATIONS Please list any medications you take (Prescription, Over the Counter, Vitamins, Herbs) please include dosage and frequency

SURGICAL OR HOSPITALIZATION HISTORY Have you ever had surgery or been hospitalized?
☐NO ☐YES if yes please list and include dates

SOCIAL HISTORY

Do you smoke? ☐NO ☐YES: packs per day:_____ years smoking:_____
If you quit, when did you stop?_____

Do you drink Alcohol? ☐NO ☐YES how much?:_____

Do you use drugs (marijuana etc)? ☐NO ☐YES please explain:_____

FAMILY HISTORY Does anybody in your family have:

Breast, Ovarian, Colon uterine or ovarian Cancer? ☐NO
☐YES if yes who is the family member what is the cancer and how old were they when they were diagnosed?_____
_____

Other Cancers? ☐NO ☐YES please describe

High blood pressure, Heart disease, Diabetes, Stroke, Osteoporosis, Bleeding disorders, Other
Please describe:

GYN & OBSTETRICAL HISTORY

Last Menstrual Period:_____ How often do you get a period?:_____
How many days do you bleed for:_____ How old where you when you had your first period?:_____ How many births have you had?: _____
Cesarean or vaginal or both:_____
Number of living children:_____ Miscarriages:_____Abortions:_____
Other: such as ectopic, please describe_____
What is your birth control method?_____
Do you have a history of an abnormal pap smear? ☐NO
☐YES please describe:_____

When was your last pap smear?:_____
Do you have a history of sexually transmitted disease(Chlamydia,HPV,Herpes,Warts,Gonorrhea, etc)?: ☐NO
☐Yes please describe_____
Have you ever engaged in any activity which has put you at risk for AIDS? ☐NO ☐YES
Do you want to be tested for HIV? ☐NO ☐YES
Do you want to be tested for sexually transmitted diseases? ☐NO ☐YES

Patient's Signature: Date:

Please indicate who referred you to our practice: