DRS. BORDERS, HOOD & ASSOCIATES
MEDICAL HISTORY QUESTIONNAIRE

BOR-07 (REV. 3-2-16)

Completion of this form will allow us to focus more atttention on issues of greatest concern to you. Please make sure to complete both sides.

PATIENT NAME: _____ **DOB:** _____

DATE OF VISIT: _____ **Reason for visit:** _____

Past Medical History: Current or past medical illnesses and hospitalizations. List surgeries below. ❑ Unchanged

_____

Past Surgical History/operations: _____ ❑ Unchanged

Family History ❑ Heart Attack ❑ Stroke ❑ Diabetes ❑ High Blood Pressure ❑ Cancer of: _____ ❑ Unchanged

Other _____

Immunizations:

Influenza in last 12 months	_____
Pneumonia (PneumoVax)	_____
Zostavax (for Shingles/Herpes Zoster)	_____
Tetanus in last 10 years (only tetanus, not also other protections)	_____
Tetanus plus Diphtheria, Pertusis {Whooping Cough} (Tdap) ever or in last 10 yrs.	_____
Other	_____

Examples
English
Caucasian

Social History:

Occupation	_____	Ethnicity (cultural group)	_____
Education Level	_____	Race (genetic group)	_____
Marital Status	_____	Caffeine Use	_____
Tobacco Use	_____	Exercise	_____
Alcohol Use	_____	Favorite Hobby	_____

Reproductive History: _____

Medication: (Prescription/vitamin/OTC) ❑ Unchanged _____

_____

_____

_____

Allergies: Medication/Food/Other _____

_____

Routine Screening

	Colonoscopy _____	Mammogram _____	Breast self-exam _____
		Pelvic exam/	
(When)	Diabetes _____	PAP smear _____	OB/GYN name _____
	Bone Density _____	Prostate/PSA _____	Urologist name _____

Review of Systems

	Circle one:		Comments by Examiner
Poor Appetite	Yes	No	
Fatigue	Yes	No	
Weight loss/gain	Yes	No	
Fevers/chills	Yes	No	
Night Sweats	Yes	No	
Any episodes of loss of vision	Yes	No	
Problem with eyes	Yes	No	
Frequent or severe headaches	Yes	No	
Trouble with hearing	Yes	No	
Ear infection/drainage	Yes	No	
Noises in ears	Yes	No	
Nasal allergies	Yes	No	
Sinusitis	Yes	No	
Throat or mouth problems	Yes	No	
Breast tenderness or problem	Yes	No	
Scarlet fever or rheumatic fever	Yes	No	
High blood pressure or medication to lower it	Yes	No	
Chest pain	Yes	No	
Palpitations	Yes	No	
High cholesterol or on medication to lower it	Yes	No	
Heart disease/heart attack	Yes	No	
Ankle swelling or varicose veins	Yes	No	

Continued on Reverse

M.D. Signature _____

PATIENT NAME: _____ **DOB:** _____

			Comments by Examiner
Awakens at night short of breath	Yes	No	
Pain in legs with walking	Yes	No	
Heart murmur	Yes	No	
Shortness of breath	Yes	No	
Daily or excessive cough	Yes	No	
Asthma or wheezing	Yes	No	
Any respiratory disorder	Yes	No	
Coughed up blood	Yes	No	
Snoring	Yes	No	
Witnessed breath holding during sleep	Yes	No	
Daytime drowsiness	Yes	No	
Trouble swallowing	Yes	No	
Heartburn/indigestion	Yes	No	
Nausea-frequent or severe	Yes	No	
Hiatal hernia or gastric reflux	Yes	No	
Stomach or intestinal ulcers	Yes	No	
Gallbladder problems	Yes	No	
Abdominal pain	Yes	No	
Black or bloody stools	Yes	No	
Frequent or severe constipation	Yes	No	
Chronic or recurrent diarrhea	Yes	No	
Excess gas	Yes	No	
Hepatitis exposure	Yes	No	
Frequent Urination	Yes	No	
Trouble controlling urine	Yes	No	
Trouble passing urine	Yes	No	
Burning or pain with urination	Yes	No	
Problems with sexual function	Yes	No	
Kidney stones	Yes	No	
History of prostate problems	Yes	No	
Hernia or rupture	Yes	No	
Skin problems or changes	Yes	No	
Loss of balance or dizziness	Yes	No	
Have you had a fall in the last year?	Yes	No	
Any episodes of seizures	Yes	No	
Any episodes of loss of consciousness	Yes	No	
Numbness, weakness or tremors	Yes	No	
Trouble speaking or understanding speech	Yes	No	
Memory loss	Yes	No	
Pain or altered sensation in legs at night	Yes	No	
Pain, swelling or stiffness of joints or muscles	Yes	No	
Back ache-frequent or severe	Yes	No	
Arthritis	Yes	No	
Enlarged glands in neck	Yes	No	
Heat or cold intolerance	Yes	No	
Thyroid trouble or goiter	Yes	No	
Excess thirst or hunger	Yes	No	
Diabetes	Yes	No	
Awakens frequently at night	Yes	No	
Excessive nervousness or anxiety	Yes	No	
Depression, frequent or severe	Yes	No	
Sleeplessness, excessive or severe	Yes	No	
Changes in stress level	Yes	No	
Bleeding tendency	Yes	No	
Anemia	Yes	No	

Other providers (hospital, emergency room, urgent care clinics, specialist, etc) you have seen leading up to this visit _____

_____

_____

Other concerns not listed above _____

_____

❑ Age Approp. Risk/Preventive Counseling Done

❑ All remaining systems are negative.

M.D. Signature _____