HCA PHYSICIAN SERVICES

Ocala Health Surgical Group

MEDICAL HISTORY QUESTIONNAIRE

Date:__________________

Name:____ Birth Date:__________________

Reason for visit:____

Referring Physican:____

Family Doctor/Primary Care Doctor:____

List other physicians that you have previously seen in the past two years and why:

- ____
- ____
- ____

PAST MEDICAL HISTORY

Please list any surgeries you have had and the year:

- ____
- ____
- ____
- ____

Please list any illnesses that have required you to be hospitalized and the year:

- ____
- ____
- ____
- ____

Please list all medications that you are currently taking and how often:

- ____
- ____
- ____
- ____

Please list any medications that you have had an allergic reaction to. Also describe the reaction:

- ____
- ____
- ____
- ____

HCA PHYSICIAN SERVICES
Ocala Health Surgical Group

List any food allergies: ____

Please review the list below and check and circle where appropriate all that describes your medical history.

- Chest Pain or Angina
- Heart Valve Disorder
- Arrhythmia / Palpitations
- Congenital Heart Disease
- COPD / Emphysema / Bronchitis / Asthma
- Congestive Heart Failure
- Diabetes ☐ Type 1 ☐ Type 2
- High Cholesterol
- High Blood Pressure / Hypertension
- Heart Attack / Coronary Heart Disease
- Rheumatic Heart Disease
- Stroke / TIA
- Heart Murmurs
- Abnormal EKG
- Headaches / Migraines
- Seizures
- Numbness or Tingling in arms, hands, legs and feet
- Weakness in arms, hands, legs and feet
- Pain in legs while walking
- Joint pain/swelling
- Leg cramps at night
- Leg cramps with exercise
- Varicose veins
- Small spider veins
- Big bulging veins
- History of blood clots in legs
- History of phlebitis
- Poor circulation
- Difficulty maintaining balance
- Dizziness
- Fainting or black-out spells
- Shortness of breath at night / while walking
- Swelling of legs, ankles or feet
- Cough
- Coughing up blood
- Easy bruising
- Excessive bleeding after cutting skin
- Weight change ☐ Weight loss ☐ Weight gain ☐

Current Weight _____________ Weight 1 year ago ______________

HCA PHYSICIAN SERVICES

Ocala Health Surgical Group

FAMILY HISTORY

	Age	State of Health	Cause of Death
Father			
Any medical problems?			
Mother			
Any medical problems?			
Brother			
Any medical problems?			
Sister			
Any medical problems?			
Other			
Any medical problems?			

PERSONAL HISTORY

History of Smoking:

How many packs per day?______________________________ For how long? _____________

Have you stopped smoking?____________________________ When did you quit?__________

History of Drinking:

How many per day?__________________________ For how long (in years) _______________

How much exercise do you get (walking, jogging, bicycling, swimming, golfing, tennis, other) please circle:

Minutes each day?_______________________________ Hours per week?________________

Whom should we contact in the event you develop a medical emergency? Please list name, phone number, and how they are related to you.

Name:_____________________________ Relationship:_____________ Phone Numbers:____________________

Name:_____________________________ Relationship:_____________ Phone Numbers:____________________

Name:_____________________________ Relationship:_____________ Phone Numbers:____________________

Name:_____________________________ Relationship:_____________ Phone Numbers:____________________