PATIENT HISTORY QUESTIONNAIRE MITCHELL CLINIC, LTD.

Name	age	sex M F	birth date

1. What type of work do you do?	marital status (please circle) married single divorced widowed

2. What other types of work have you done?

3. Have you ever lived overseas? If so where?

4. Tobacco usage	yes	no	amount per day	# of years	Beverage consumption	yes	no	amount per day
Cigarettes					Alcoholic beverages			
Cigar					Coffee or tea			
Pipe / chew					Caffiene containing soda pop			
If not, have you ever smoked?					When did you stop smoking?			

What drugs or medicines do you take regularly? (These include medicines that were prescribed by a physician and also medicines or vitamins that you can buy yourself without a prescription)	Name of prescription medicine	Amount per day	Name of nonprescription medicine or drug	Amount per day
	1.		1.	
	2.		2.	
	3.		3.	
	4.		4.	
	5.		5.	
	6.		6.	
	7.		7.	

What foods or medicines are you allergic to?	1.	2.	3.
	4.	5.	6.

	Type	Hospital	Date
What surgeries have you had?	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
	Reason for hospitalization	Hospital	Date
What other hospital-izations have you had?	1.		
	2.		
	3.		
	4.		
	5.		
	6.		

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH (list any medical problems)	IF DEAD, CAUSE OF DEATH (be specific)	Age at Death
FATHER				
MOTHER				
B S				
B S				
B S				
B S				
B S				
B S				

IS THERE A HISTORY OF ANY OF THE FOLLOWING IN YOUR FAMILY?

	YES	NO		YES	NO		YES	NO
TB			HEART DISEASE			INSANITY OR IDIOCY		
DIABETES			SKIN DISEASE			CANCER		
KIDNEY DISEASE			BLOOD DISEASE			FREE BLEEDING IN FAMILY		

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO		YES	NO		YES	NO
A STROKE			HIGH BLOOD PRESSURE			ANEMIA		
MIGRAINE HEADACHES			STOMACH OR DUODENAL ULCER			GOUT		
A SEIZURE			GALLSTONES			DIABETES		
THYROID PROBLEMS			YELLOW JAUNDICE			ARTHRITIS		
ASTHMA			PANCREATITIS			BLEEDING DISORDER		
EMPHYSEMA			KIDNEY STONE			CANCER (state type)		
TUBERCULOSIS			KIDNEY INFECTION					
HEART ATTACK			BLADDER INFECTION			MENTAL ILLNESS		
HEART FAILURE			PROSTATE PROBLEM					
HEART MURMUR			VENEREAL DISEASE (state type)					
RHEUMATIC FEVER								

Please list other problems not specified above.

Please list broken bones or injuries which required a physicians care (give dates)		TODAYS DATE

THIS SECTION FOR WOMEN ONLY

Age at onset of menstruation	When was your last normal period?	Number of pregnancies
Number of living children	Number of stillborn or miscarriages	

S&M 492