BROADWAY SPORTS & INTERNAL MEDICINE, P.S.

1600 116TH AVE NE SUITE 202
BELLEVUE, WA 98004
P: 206 215-2288 F:206 215-2289

MEDICAL HISTORY QUESTIONNAIRE

Date_____ Name_____ Date of Birth _____ HT_____ WT_____

Current Medical Complaints

1._____

2._____

3._____

4._____

Medication Allergies/Sensitivities

1._____

2._____

3._____

Hospitalizations (please list on back if more**)**

1._____

2._____

Medical Problems Previously Treated

1._____

2._____

3._____

Current Medications

1._____

2._____

3._____

4._____

5._____

Drugs Frequently or Presently Used:

__Sleeping Pills
__Tranquilizers
__Anti-Depressant
__Diet Pills
__Estrogen Hormone
__Birth Control Pill
__Laxative
__Decongestant
__Diabetic Pill
__Asthma Pill
__Nitroglycerin
__Iron
__Thyroid
__Heart Pill
__Digitalis
__Water Pill
__Blood Pressure Pill
__Antacids
__Vitamin D
__Vitamins
__Antibiotics
__Insulin
__"Recreational Drugs"
__Other

Surgeries/Accidents

1._____

2._____

3._____

Date of Last Mammogram _____

Date of Last Colonoscopy _____

Date of Last Glaucoma Check _____

Living Will Yes or No

Social History:

Occupation_____ **Marital Status**: S M W D

Smoking:
Packs Per Day_____
Years Smoked_____
Years Stopped_____
Pipe_____ Cigar_____Chew_____

Alcohol
Drinks Per Day_____

Aspirin
Tabs Per Day _____

Coffee
Cups Per Day _____

Vaccinations/Injections

__Tetanus	_____Date	__Hepatitis B	_____Date
__Pneumonia	_____Date	__Flu	_____Date
__Measles	_____Date	__Shingles	_____Date
__Hormone	_____Date	__Other_____	_____Date
__Hepatitis A	_____Date		

FAMILY HISTORY

Please provide your **FAMILY's** health history below by checking the boxes for mother and father, and specifying other relatives (grandfather, for example) on the line provided. Family includes mother, father, brothers, sisters and grandparents.

Mother	**Father**	**Other Relative** (Which one)	
____	____	_____	**High Blood Pressure**
____	____	_____	**Heart Disease**
____	____	_____	**Breast Cancer**
____	____	_____	**Colon Cancer**
____	____	_____	**Other Cancer**
____	____	_____	**Mental Illness**
____	____	_____	**Stroke**
____	____	_____	**Diabetes**

HAVE YOU ANY OF THE FOLLOWING IN THE LAST THREE MONTH

	No	**Yes, Please Explain**
Fever	_____	_____
Chills	_____	_____
Sweats	_____	_____
Weight Loss/Gain	_____	_____
Fatigue	_____	_____
Weakness	_____	_____
Skin Rash, Lumps, Nodules	_____	_____
Tumor or swelling	_____	_____
Headaches	_____	_____
Eye Troubles	_____	_____
Ear Troubles		
-Pain	_____	_____
-Hearing Loss	_____	_____
-Ringing	_____	_____
-Imbalance/Dizziness	_____	_____

	No	Yes, Please explain
Nose Troubles-sinusitis		
-Bleeding	_____	_____
-Stuffiness	_____	_____
-Drainage	_____	_____
-Hay Fever	_____	_____
Throat troubles		
-Hoarseness	_____	_____
-Pain	_____	_____
Lymph node swelling	_____	_____
Lung troubles		
-Shortness of breath @ rest	_____	_____
-Shortness of breath @ exercise	_____	_____
-Sleeps sitting up due to S.O.B	_____	_____
-Awakens at night due to S.O.B	_____	_____
-Wheezing	_____	_____
-Asthma	_____	_____
-Cough	_____	_____
-Pneumonia	_____	_____
-Bronchitis	_____	_____
Heart troubles		
-Chest pain	_____	_____
-Skipping heart beats	_____	_____
-Irregular heart rhythm	_____	_____
-Heart murmur	_____	_____
-Heart failure	_____	_____
-Black out spells	_____	_____
-Hypertension	_____	_____
-Low blood pressure	_____	_____
-Ankle swelling	_____	_____
GI Problems		
-Loss of Appetite	_____	_____
-Fills up quickly with eating	_____	_____
-Pain with swallowing	_____	_____
-Food catching with swallowing	_____	_____
-Pain with hot/cold/fuzzy drinks	_____	_____
-Abdominal pain	_____	_____
-Nausea/Vomitting	_____	_____
-Vomitting blood	_____	_____

HAVE YOU EVER EXPERIENCE ANY OF THE FOLLOWING:

	No	Yes, Please explain
Heartburn/indigestion	_____	_____
Nervous stomach	_____	_____
History of stomach ulcers	_____	_____
Diarrhea	_____	_____
Constipation	_____	_____
History of colitis	_____	_____

	No	Yes, please explain
Irritable bowel	_____	_____
Hemorrhoids	_____	_____
Rectal bleeding	_____	_____
Rectal pain	_____	_____
Gallbladder trouble	_____	_____
Hepatitis	_____	_____
Liver problems	_____	_____
Urology		_____
-Trouble with urination	_____	_____
-Trouble stopping urination	_____	_____
-Burning	_____	_____
-Frequent urination	_____	no of times per day_____
-Night time urination	_____	_____
-Urination with cough or sneeze	_____	_____
-Blood in urine	_____	_____
-Kidney stones	_____	_____
-Urinary tract infection	_____	_____
Bruise easily	_____	_____
Bleeding problems	_____	_____
Varicose veins	_____	_____
Phlebitis	_____	_____
Muscle cramps	_____	_____
Muscle aches arms/legs	_____	_____
Dizziness	_____	_____
Vertigo	_____	_____
Lightheadedness	_____	_____
Feeling faint	_____	_____
Numbness in extremities	_____	_____
Weakness in extremities	_____	_____
Joint pains or stiffness		
-Fingers	_____	_____
-Wrists	_____	_____
-Elbows	_____	_____
-Shoulders	_____	_____
-Hips	_____	_____
-Knees	_____	_____
-Ankles	_____	_____
-Feet	_____	_____
Neck pain	_____	_____
Back pain	_____	_____
Bursitis	_____	_____
Thyroid problems	_____	_____
Thirsty	_____	_____
Dry skin	_____	_____
Oily skin	_____	_____
Cold all the time	_____	_____
Too Warm	_____	_____

	No	Yes, Please explain
Diabetes (includes pregnancy)	_____	_____
Low blood sugar	_____	_____
High cholesterol	_____	_____
Depression	_____	_____
Sleeping problems	_____	_____
Snoring	_____	_____
Anxiety	_____	_____
Nervous	_____	_____
Irritable	_____	_____
Anger problems	_____	_____
Diet	_____	_____
-Fat intake	High	Medium Low
-Salt intake	High	Medium Low
Aerobic exercise frequence		How long_____
Do you utilize seatbelts?	_____	_____
Do you use a bike helmet?	_____	_____
Females Only		
Pregnant	_____	_____
Preform self breast exam?	_____	_____
Breast lumps, nodules	_____	_____
Breast milk discharge	_____	_____
Breast biopsy	_____	_____
Date of Last pap	_____	
History of abnormal pap	_____	_____
History of genital warts	_____	_____
History of genital herpes	_____	_____
Vaginal discharge	_____	_____
Vaginal itch or bad odor	_____	_____
Vaginal bleeding	_____	_____
Abnormal periods	_____	_____
Hot Flashes	_____	_____
Other STD history	_____	_____
Males Only		
Erection dysfunction	_____	_____
Testicular cancer screening	_____	_____
Sterility	_____	_____
Premature ejaculation	_____	_____
Impotence	_____	_____
Abnormality of Male Genitalia	_____	_____
Potency	_____	_____
Failure to maintain erection	_____	_____
Discharge	_____	_____
STD history	_____	_____
Preformed self exam for		
testicular mass/lumps	_____	_____
Date of last PSA	_____	