600 West Cummings Park, Suite 3400
Woburn, Massachusetts 01801-6350
(781) 935-8581 • Fax (781) 938-4678
www.allonehealth.com

General Medical Questionnaire

Try to answer all questions as correctly as possible, even if they do not seem to be important to you.

Name:
Date:
Address:
City:
State:
Zip:
Personal Physician:
Name of Employer:
Job Title:
Social Security #:
Date of Birth:
Home Phone:
Business Phone:

Type of Exam:

- ☐ Executive
- ☐ Pre-Placement
- ☐ Annual
- ☐ Exit

MEDICAL HISTORY AND PHYSICAL EXAM

PERSONAL HISTORY

Marital Status ☐ single ☐ married ☐ separated ☐ divorced widowed				Country of Birth	
# Of Children	Do you follow a special diet? (ex.: low salt, vegetarian) ☐ no ☐ yes (if yes, name diet):			Average # of meals eaten/day	
Do you smoke? ☐ Yes ☐ No	#packs smoked/day	Have you smoked in the past?	#Yrs. Smoked	Quite Date:	
Caffeine intake: # of cups coffee/tea/cola per day		How many times per week do you exercise? Type of Exercise:		Seat belt usage ☐ Always ☐ 50% time ☐ Never	
Do you ever drink alcoholic beverages? ☐ Yes ☐ No	If yes, how many servings do you have in a week?			When was your last drink?	
Have you ever had a drug or alcohol problem?		If yes, explain:			

OCCUPATIONAL HISTORY

Usual Occupation	Present Job	Number of years at present occupation:
Have you ever been injured at work? ☐ Yes ☐ No	If yes, give date and describe:	Have you ever rec'd Workers' Comp? ☐ Yes ☐ No
Have you ever been exposed to any known toxic chemicals, pesticides, radiation, asbestos, lead, excessive noise, beryllium, coal dust, silica, cotton dust, heavy metals? ☐ Yes ☐ No	If yes, what, give dates and described how exposed: Any known adverse effect?	

MILITARY SERVICE/FOREIGN TRAVEL:

IMMUNIZATIONS

Immunization	**Date**	**Immunization**	**Date**	**Immunization**	**Date**	**BCG (TB Vaccination)**	**Date**
Diphtheria Tetanus		**Mumps**		**Pneumonia Vaccine**		**Other:**	**Date:**
				Measles			
Polio		**Rubella (German Measles)**		**TB Test Results (most recent)** **Date:**		**Result:**	
Influenza		**Hepatitis B Vaccine**		**Last Chest X-Ray** **Date:**		**Result:**	

PRESENT MEDICATIONS

Drug	**Dose/Time**	**Drug**	**Dose/Time**	**ALLERGIES (Medication & Environmental)**
1 .		7.		
2.		8.		
3.		9.		
4.		10.		
5.		11.		
6.		12.		

Comments and/or Explanations

MEDICAL HISTORY AND PHYSICAL EXAM

Have you ever had any of the following? (check appropriate boxes)

- ☐ Angina
- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Liver Disease

- ☐ Hepatitis
- ☐ Arthritis
- ☐ Epilepsy/Seizure Disorder
- ☐ Claustrophobia (fear of enclosed spaces)
- ☐ Asthma
- ☐ Pneumonia
- ☐ TB
- ☐ Psychiatric Illness

- ☐ Bleeding Disorders
- ☐ Skin Rashes
- ☐ Thyroid Disease
- ☐ Depression
- ☐ Anxiety
- ☐ Malaria
- ☐ Venereal Disease

- ☐ Rheumatic Fever
- ☐ Chicken Pox
- ☐ Measles
- ☐ German Measles
- ☐ Mumps
- ☐ Polio
- ☐ Allergies

Comments:

Past History

Hospitalizations/Operations	Complications	Year	Hospital
1.			
2.			
3.			
4.			

Accidents/Injuries (i.e., broken bones/fractures, sprains, strains, including cartilage & ligament injuries). Describe and Date:

Family History

Member	Age	Good Health	Poor Health	Deceased	Cause of Death	Heart Disease	High Blood Pressure	Artery Disease Stroke	Diabetes	Cancer	Glaucoma	Psychiatric Disorders	Allergies	Respiratory Disease	TB	Other
Mother																
Father:																
Brother/Sister 1. 2. 3. 4.																
Child: 1. 2. 3. 4.																
Other:																

MEDICAL HISTORY AND PHYSICAL EXAM

REVIEW OF SYSTEMS Do you have an existing and/or recent problem with:

			Yes	No				Yes	No
General	Anemia	1	☐	☐	Oral	Seen by dentist within last year	37	☐	☐
	Fevers	2	☐	☐		Gums bleed easily	38	☐	☐
	Recent loss/gain in past 6 months	3	☐	☐		Teeth	39	☐	☐
	Chills or fever	4	☐	☐		Sense of taste	40	☐	☐
	Night sweats	5	☐	☐	Lungs	Cough	41	☐	☐
	Swollen glands	6	☐	☐		Sputum	42	☐	☐
	Swelling in your groin or armpit	7	☐	☐		Cough up blood	43	☐	☐
	Fatigue	8	☐	☐		Shortness of breath	44	☐	☐
	Allergies	9	☐	☐		Wheezing	45	☐	☐
Skin	Rashes	10	☐	☐		Pneumonia	46	☐	☐
	Poor healing	11	☐	☐		Bronchitis	47	☐	☐
	Easy bruising	12	☐	☐		Emphysema	48	☐	☐
	Change in lumps/moles	13	☐	☐	Heart	Chest Pain	49	☐	☐
Eyes	Blurring	14	☐	☐		Shortness of breath	50	☐	☐
	Double vision	15	☐	☐		on exertion	A	☐	☐
	Pain	16	☐	☐		at rest	B	☐	☐
	Cataracts	17	☐	☐		Palpitations	51	☐	☐
	Glaucoma	18	☐	☐		Ankle swelling	52	☐	☐
	Wear glasses/contacts	19	☐	☐		Rheumatic fever	53	☐	☐
	Date of last eye exam:	20	☐	☐		Heart murmur	54	☐	☐
Ears	Wear hearing aid	21	☐	☐		Irregular heart beat	55	☐	☐
	Ringing	22	☐	☐	Breasts	Lumps	56	☐	☐
	Deafness/trouble hearing	23	☐	☐		Discharge	57	☐	☐
	Infections	24	☐	☐		Mammography	58	☐	☐
Nose,	Infections	25	☐	☐	Abdomen	Nausea/vomiting	59	☐	☐
Sinus	Bleeding	26	☐	☐		Change in bowel habits	60	☐	☐
	Nasal congestion without a cold	27	☐	☐		Bloody stools	61	☐	☐
Throat	Infections/strep	28	☐	☐		Black tarry stools	62	☐	☐
	Hoarseness	29	☐	☐		Heartburn	63	☐	☐
	Trouble Swallowing	30	☐	☐		Ulcer disease	64	☐	☐
Endocrine	Thyroid problems	31	☐	☐		Diarrhea	65	☐	☐
	Cold intolerance	32	☐	☐		Constipation	66	☐	☐
	Heat intolerance	33	☐	☐		History of jaundice	67	☐	☐
	Excessive thirst	34	☐	☐		Abdominal pain	68	☐	☐
	Excessive hunger	35	☐	☐		Hernia	69	☐	☐
	X-ray treatment to head, neck	36	☐	☐		Food intolerance	70	☐	☐
					Genito-urinary	Urgency	71	☐	☐
						Increased frequency	72	☐	☐
Comments and/or Explanations:						Burning	73	☐	☐
						Bleeding	74	☐	☐
						Kidney stones	75	☐	☐
						Infections	76	☐	☐

MEDICAL HISTORY AND PHYSICAL EXAM

REVIEW OF SYSTEMS (continued) Do you have an existing and/or recent problem with:

			Yes	No				Yes	No
Bones/	Back pain/injury/surgery	77	☐	☐	Women	Bleeding between periods	100	☐	☐
Joints	Pain	78	☐	☐	Only:	Regular monthly periods	101	☐	☐
	Stiffness	79	☐	☐		Have you ever taken birth control pills	102	☐	☐
	Swelling	80	☐	☐					
	Tenderness	81	☐	☐		DES exposure	103	☐	☐
	Pain on motion	82	☐	☐		Pap test within a year	104	☐	☐
	Limited motion	83	☐	☐		Pain with periods	105	☐	☐
Vascular	Circulation problems	84	☐	☐		Sexual difficulty	106	☐	☐
	Leg cramps	85	☐	☐		Latest menstrual period – date:	107		
	Varicose veins	86	☐	☐		# Days menstrual flow			
	Phlebitis	87	☐	☐		# Days menstrual cycle			
Nerves	Seizures	88	☐	☐		# Pregnancies			
	Tremors	89	☐	☐		# Abortions			
	Fainting	90	☐	☐		# Miscarriages # Births			
	Numbness	91	☐	☐					
	Weakness	92	☐	☐	Men	Discharge from penis	108	☐	☐
	Dizziness	93	☐	☐	Only:	Prostate trouble	109	☐	☐
	Trouble speaking	94	☐	☐		Dribbling	110	☐	☐
	Trouble walking	95	☐	☐		Sexual difficulty	111	☐	☐
	Anxiety	96	☐	☐					
	Depression	97	☐	☐					
	Difficulty sleeping	98	☐	☐					
	Headaches	99	☐	☐					

Mark as many as apply:

112 Within the past 6 months have you had a problem with:
☐ appetite ☐ falling asleep ☐ staying asleep ☐ trembling ☐ tension ☐ relaxing ☐ stress ☐ none

113 During the past year have emotional problems affected your work or personal life enough to require treatment? ☐ Yes ☐ No

If yes, explain

Comments and/or Explanation of Positive or Abnormal Responses: