BAY AREA INFECTIOUS DISEASE ASSOCIATES

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____

Current Medications (include dose and frequency)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (Medication, Food, Environmental. Please provide reaction)

_____

_____

_____

Prior Medical History (Please select all that apply)

- ☐ Allergies _____
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety/Panic Attacks
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bladder Infection
- ☐ Cancer Type: _____
- ☐ Cataracts
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Headaches/Migraines
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hypertension/High Blood Pressure
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Infection
- ☐ Kidney Stone(s)
- ☐ Low Back Problems/Pain
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Prostate Trouble
- ☐ Seizures
- ☐ STD/STI (Sexually Transmitted Disease/Infection)
- ☐ Sickle Cell Anemia
- ☐ Sinus Issues
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer Type: _____
- ☐ Other: _____

_____

_____

Previous Surgical History (Please provide date or age)

- ☐ Appendix _____
- ☐ Breast _____
- ☐ Cardiac _____
- ☐ Gallbladder _____
- ☐ Hernia _____
- ☐ Hysterectomy _____
- ☐ Tonsils _____
- ☐ Tubal Ligation _____
- ☐ Prostate _____
- ☐ Other _____

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PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____

Hospitalizations (Please include hospital name(s), date(s), reason)

_____

_____

Immunizations (Please include date, year, or age)

☐ Covid _____ ☐ Meningococcal _____ ☐ Tetanus _____

☐ Hepatitis A / B _____ ☐ MMR _____ ☐ Varicella (Chicken Pox) _____

☐ HPV _____ ☐ Pneumonia _____

☐ Influenza _____ ☐ Shingles _____ ☐ PPD Test & Result _____

Personal History

☐ Current Smoker

Quantity per day? _____

☐ Former Smoker

When did you quit? _____

☐ Alcoholic Beverages

Weekly Consumption _____

☐ Caffeine

Daily Consumption _____

☐ Recreational Drug Use

Type/Frequency _____

Family Medical History (Immediate Family Only)

Family Member	Age	Alive	Deceased	Health Problems
Father				
Mother				
Sister / Brother				