Meridian Health Services
MEDICAL HISTORY QUESTIONNAIRE

The following information is very important to your health. This is a confidential record of your medical history. Information contained here will not be released to anyone except when you have authorized us to do so. Please take the time to fully and completely fill out this form.

PATIENT NAME: **DATE OF BIRTH:** **TODAY'S DATE:**

CURRENT MEDICATIONS:					
Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

☐ List additional medications on the back of this page.

ALLERGIES:	
Are you allergic to any medications (including tape, iodine, x-ray dye, or latex)? ☐ YES ☐ NO	
Name of Medication	Type of Reaction You Experienced:

☐ List additional allergies on the back of this page.

SOCIAL HISTORY				
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed			
Highest Level of Education:				
Number of Household Members, including yourself:				
Current Occupation:				
Tobacco Use:	☐ Never	☐ Smoke	☐ Chew	☐ Smoke & Chew
Use:	☐ Every Day ☐ Former Smoker	☐ Socially ☐ Secondary Exposure	☐ Rarely ☐ Other	
Packs Per Day:		Years Smoked:		
Alcohol Use:	☐ Never	☐ Beer	☐ Wine	☐ Liquor
Use:	☐ Every Day	☐ Socially	☐ Rarely	☐ Former Drinker ☐ Other
Drinks Per Day:		Years of Consumption:		
Substance Use:	☐ Never ☐ Reports ☐ Secondary Exposure			
☐ Amphetamines	☐ Cocaine	☐ Club Drugs	☐ Hallucinogens	
☐ Inhalants	☐ Injection Drugs	☐ Marijuana	☐ Opiates	
☐ Pain Killers	☐ Prescription Drugs	☐ Tranquilizers / Sedatives	☐ Other	
Faith & Religion:	☐ Baptist ☐ Catholic ☐ Christian ☐ Lutheran ☐ Methodist ☐ Nazarene ☐ Presbyterian ☐ Protestant ☐ Other ☐ None			
Dietary Habits:	Well Balanced Diet?	☐ Most Days ☐ Occasionally ☐ Rarely ☐ Never ☐ Other		
Caffeine Intake:	☐ Coffee ☐ Tea ☐ Soda	☐ Daily ☐ 2-3 times/week ☐ Rarely ☐ Never ☐ Other		
Exercise Habits:	☐ Never ☐ Seldom ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5-6 times/week ☐ Daily ☐ Other			

MERIDIAN MD
Family Medical Care

Please check those conditions that apply to you and/or your family:

MEDICAL CONDITION	YOU	MOTHER	FATHER	GRAND PARENT	BROTHER	SISTER	OTHER RELATIVE
ADD / ADHD	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Atrial Fibrillation	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐
Cancer - TYPE: _____	☐	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐
Cerebral Palsy	☐	☐	☐	☐	☐	☐	☐
Cirrhosis	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐
Coronary Artery Disease	☐	☐	☐	☐	☐	☐	☐
Degenerative Disc Disease	☐	☐	☐	☐	☐	☐	☐
Degenerative Joint Disease	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Down's Syndrome	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐
Erectile Dysfunction	☐	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐	☐
GERD	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Hyperthyroidism	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐
Kidney Failure (Renal Failure)	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐	☐
Methicillin-Resistant Staphylococcus Aureus (MRSA)	☐	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐

Please check those conditions that apply to you and/or your family:

MEDICAL CONDITION, Cont.	YOU	MOTHER	FATHER	GRAND PARENT	BROTHER	SISTER	OTHER RELATIVE
Obsessive Compulsive Disorder	☐	☐	☐	☐	☐	☐	☐
Osteomyelitis (Bone Infection)	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Paralysis	☐	☐	☐	☐	☐	☐	☐
Premenstrual Syndrome (PMS)	☐	☐	☐	☐	☐	☐	☐
Post-Traumatic Stress Disorder (PTSD)	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐
Restless Leg Syndrome	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐
Sexually Transmitted Diseases	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Tobacco Abuse	☐	☐	☐	☐	☐	☐	☐
Urinary Incontinence	☐	☐	☐	☐	☐	☐	☐
OTHER	☐	☐	☐	☐	☐	☐	☐

SURGICAL HISTORY

Type of Surgery	Date or Age	Type of Surgery	Date or Age