AXIOM CLINICAL RESEARCH
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Medical History Questionnaire

Patient Name: _____ Date: _____

Patient ID: _____ DOB: _____ Age: _____

Height: _____ Weight: _____

Has a doctor in this office previously seen you? _____

Referring Physician: _____

Reason for Visit:

_____

_____

PERSONAL MEDICAL HISTORY

List known drug allergies or _____**NA** _____

Have you had any of the following?

Problem		Date of Onset	Disorder		Date of Onset
High Blood Pressure	____Yes ____No		**General**		
Diabetes	____Yes ____No		Fatigue	____Yes ____No	
Cancer	____Yes ____No		Weight Loss	____Yes ____No	
Heart Attack	____Yes ____No		Fever	____Yes ____No	
Stroke	____Yes ____No		**Skin**		
TIA	____Yes ____No		Rash	____Yes ____No	
Seizures	____Yes ____No		Skin Cancer	____Yes ____No	
Kidney Failure	____Yes ____No		**Head/Neck**		
Other	____Yes ____No		Headaches	____Yes ____No	
Respiratory			Head Injury	____Yes ____No	
Cough	____Yes ____No		Neck Pain	____Yes ____No	
Asthma	____Yes ____No		Neck Injury	____Yes ____No	
Shortness of Breath	____Yes ____No		Blurred Vision	____Yes ____No	
Tuberculosis	____Yes ____No		Hearing Loss	____Yes ____No	
Pneumonia	____Yes ____No		Ears Ringing	____Yes ____No	
Cardiac			Vertigo	____Yes ____No	
Angina	____Yes ____No		Nose Bleeds	____Yes ____No	
Irregular Heartbeat	____Yes ____No		Loss of Smell	____Yes ____No	
Heart Murmur	____Yes ____No		Hoarseness	____Yes ____No	
Heart Attack	____Yes ____No		Swallowing Issues	____Yes ____No	
Rheumatic Fever	____Yes ____No		**Gastrointestinal**		
Renal/Urinary			Hepatitis	____Yes ____No	
Bladder Problems	____Yes ____No		Appetite Changes	____Yes ____No	
Blood In Urine	____Yes ____No		Nausea	____Yes ____No	

Behavioral			Vomiting	**____Yes ____No**	
Substance Abuse	**____Yes ____No**		Blood in Stool	**____Yes ____No**	
STDs	**____Yes ____No**			**____Yes ____No**	
Problem		**Date of Onset**	**Problem**		**Date of Onset**
Gynecological			**Hematological**		
Irregular Mens. Cycle	**____Yes ____No**		Transfusions	**____Yes ____No**	
Abnormal Bleeding	**____Yes ____No**		Anemia	**____Yes ____No**	
Contraceptive Use	**____Yes ____No**		Abnormal Bleeding	**____Yes ____No**	
Pregnancy	**____Yes ____No**		Cancer	**____Yes ____No**	
Endocrine			**Emotional**		
Diabetes	**____Yes ____No**		Anxiety	**____Yes ____No**	
Thyroid Problems	**____Yes ____No**		Depression	**____Yes ____No**	
Bone and Joints			Bipolar Disorder	**____Yes ____No**	
Pain	**____Yes ____No**		Psychosis	**____Yes ____No**	
Swelling	**____Yes ____No**		Insomnia	**____Yes ____No**	
Injury	**____Yes ____No**		Suicidal Thoughts	**____Yes ____No**	
Arthritis	**____Yes ____No**		Psych Treatment	**____Yes ____No**	

Please List all Surgical Procedures and Hospitalizations:	
Procedure/Hospitalization	**Date**

Social History	
Marital Status	
Employment Status	
Do you have children?	
Have you ever smoked?	
Alcohol Use	

Do you have a family history of the following?		
Problem		**Relationship**
Stroke	**____Yes ____No**	
Heart Attack	**____Yes ____No**	
Seizures	**____Yes ____No**	
Dementia	**____Yes ____No**	
Other	**____Yes ____No**	
Other	**____Yes ____No**	