Advanced Mobile Healthcare, LLC
9505 west Central, Ste. 104
Wichita, Ks. 67212
(316) 312-0002
Fax: (316) 854-5644
amhcare.com

# .MEDICAL HISTORY QUESTIONNAIRE

Thank you for taking the time to fill out this valuable information. This allows us to provide the best care possible. Please use additional pages to write any information not included here you think is important.

**Name:**_____ **Birth date:** _____ **Date:** _____
**Person filling out form:** _____ **Relationship:** _____
**Main reason for visit**: _____

**1. Current/Past Medical Problems**: Example Strokes, Heart trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye problems, etc.

| Current or Past Medical Problem | Year of diagnosis |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |

**2. Past Surgeries**: Example Gall Bladder removed, Appendectomy, Hysterectomy with or without ovaries removed, Cataract surgery, Prostate surgery, Heart surgery, etc.

| Past Surgery | Approximate Date of Surgery |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |

**3. Recent Hospitalizations:** List reason for any recent hospitalizations in **past 2 years**.

| Reason for Hospitalization | Name of Hospital | Date |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

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**4. Recent Trips to Emergency Room:** List reason for recent trips to emergency room (ER) **in the past 2 years** and emergency room you used.

| Reason for Trip to ER | Name of ER | Date |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

**5. Recent Doctors:** List all recent doctors, their specialty (e.g. Primary doctor, cardiologist, neurologist, etc.) and their phone number and fax number (if known).

| Doctor Name | Specialty | Phone | Fax |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**6. Medical Allergies** and reaction: Example rash, swelling, trouble breathing, etc.

| Medicine Allergies | Reaction | Medicine Allergies | Reaction |
|---|---|---|---|
| **1.** | | **2.** | |
| **3.** | | **4.** | |
| **5.** | | **6.** | |

**7. Medications: Please list both prescription and over the counter medications** (such as pain relievers, constipation medicine, heart burn medicine, vitamins, etc.). Give estimated frequency of use of as needed meds.

| Medication and Strength (mg or mcg, etc.) | How Often Taken or As Needed |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |
| 11. | |
| 12. | |
| 13. | |
| 14. | |

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**8. Local Pharmacy**: _____ Phone #: _____
**Mail Order Pharmacy**: _____ Phone #: _____
Member ID #: _____ Fax #: _____

**9. Family History:** List medical problems of close family members (example dementia, cancer and what type, heart disease, stroke, diabetes, hypertension, depression, etc.), if anyone has died, the age of death and the cause of death.

| Family Member | Alive/Deceased | List Any Medical Problems and/or cause of death |
|---|---|---|
| Father | | |
| Mother | | |
| | | |
| | | |

**10. Social History:**

**Tobacco Use**: □ Never □ Current □ Past Quit date: _____
Type: □ Cigarette Packs per day on average: _____ Years smoked: _____
□ Cigar □ Pipe □ Chewing

**Alcohol Use:** □ None □ Rarely □ 1-2 drinks/month □ 1-2 drinks/week □ 1-2 drinks/day
Was drinking too much alcohol ever a problem for you? □ Yes □ No

**Illegal Drug Use:** □ Never □ Current □ Past Type _____ Quit date: _____

**Advance Directives:** □ Living Will □ Durable Power of Attorney for Healthcare
Name and relationship:_____ □ Do Not Resituate Form
Would you like information on Advanced Directives? □ Yes □ No

*****If you have any of the above documents please have a copy of them made for us to place in their chart.**

**11. Medicare Home Health Agency:** □ Yes □ No

| | | | |
|---|---|---|---|
| **Name:** | | **Phone** #: | |
| **Nurse:** | □ Yes □ No | **Physical therapy:** | □ Yes □ No |
| **Speech Therapy:** | □ Yes □ No | **Occupational Therapy:** | □ Yes □ No |

**The above information is correct to the best of my knowledge.**

**X**_____ **Date:** _____
**Signature of Patient/Parent/Guardian**