

Medical Questionnaire – Samaritan Infectious Disease

Name _____ Date of Birth _____ Today's Date _____

Please provide details of you medical history below:

Check all that apply: (Provide additional detail below if needed)		
<u>MEDICAL HISTORY</u>		<u>SURGICAL HISTORY</u>
Cardiovascular Disease	<input type="checkbox"/> HIV	
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Other sexually transmitted disease:	<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Angina pectoris	Specify:	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> <i>Clostridium difficile</i> (C. diff)	<input type="checkbox"/> Coronary artery bypass
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> MRSA infection	<input type="checkbox"/> Heart valve replacement
<input type="checkbox"/> Pacemaker or defibrillator		<input type="checkbox"/> Joint Replacement (specify):
<input type="checkbox"/> Hypertension	Kidney Disease	1.
<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Kidney failure	2.
Endocrine/Metabolic	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Gall bladder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Thyroid disorder		<input type="checkbox"/> Breast
<input type="checkbox"/> High Cholesterol	Musculoskeletal Disease	<input type="checkbox"/> Colon
	<input type="checkbox"/> Arthritis , degenerative	<input type="checkbox"/> Hernia
Gastrointestinal Disease	<input type="checkbox"/> Arthritis, inflammatory (lupus, etc.)	<input type="checkbox"/> Splenectomy
<input type="checkbox"/> Reflux	<input type="checkbox"/> Chronic back pain	<input type="checkbox"/> Other surgeries (please list):
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Gout	1.
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Fibromyalgia	2.
<input type="checkbox"/> Ulcerative colitis	Neurologic Disease	3.
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Seizure disorder	4.
	<input type="checkbox"/> Stroke/TIA	<u>FAMILY HISTORY</u>
Hematology/Cancer	<input type="checkbox"/> Chronic headaches/migraine	<input type="checkbox"/> Heart attack before age 60
<input type="checkbox"/> Anemia		<input type="checkbox"/> Cancer
<input type="checkbox"/> Blood Clots	Psychiatric Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer – what type(s)	<input type="checkbox"/> Suicide attempt	<input type="checkbox"/> Hypertension
1.	<input type="checkbox"/> Other mental illness	<input type="checkbox"/> Other:
2.		
	Respiratory Disease	<u>MISCELLANEOUS HISTORY</u>
Infectious Disease	<input type="checkbox"/> COPD	<input type="checkbox"/> X-ray dye allergy
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Asthma	<input type="checkbox"/> Latex allergy
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Frequent pneumonia	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Chronic sinusitis	

Social History/Habits	Other pertinent details of past medical history Please include history of significant injuries:
<input type="checkbox"/> Occupation:	
<input type="checkbox"/> Smoker? Packs per day:	
<input type="checkbox"/> Former smoker? When quit?	
<input type="checkbox"/> Alcohol? Drinks per day:	
<input type="checkbox"/> "Recreational" drug use currently?	
<input type="checkbox"/> History of injectable drug use	

