Milepost Medical
Adult Medical Questionnaire

Name:_____ Date:_____

Reason for today's visit:

Past Medical History: Please mark if you or your family members have had any of the following:

	Self	Father	Mother	Sibling	Child	Other
High Blood Pressure						
Heart Attack/Stent						
Heart Failure						
Arrhythmia						
High Cholesterol						
Diabetes						
Thyroid Problems						
Cancer (Type)						
COPD/Emphysema						
Asthma						
Sleep Apnea						
Stomach Ulcers						
Seizures						
Migraines						
Depression						
Anxiety						
Other Psychiatric Illness						
Alcoholism						
Kidney Problems						
Stroke or TIA						
Allergies/Hayfever						
Arthritis						
Osteoporosis/Fracture						
Anemia						

Other:

Surgical History: Please mark if you have had any of these surgeries (what YEAR)

Heart Bypass	
Angioplasty/Stents	
Pacemaker	
Appendix Removal	
Gallbladder Removal	
Tonsil Removal	
Hernia Repair	
Back Surgery	
C-Section	
Tubal Ligation	
Hysterectomy	
Vasectomy	
Breast Augmentation	
Mastectomy	
Breast Lump Removal	
Cataracts	
Joint Surgery (Type)	
Other:	

MEDICATIONS: Please list all prescription, over-the-counter, or supplement medications you are taking.

Medication	Dosage	Frequency	Reason for Taking	Need refill today?
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No

Allergies to Medication/Food/Other: PLEASE DESCRIBE THE REACTION (rash, nausea, etc)

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Are you CURRENTLY having any of the following symptoms?					
Fever		Wheezing		Arm/Leg Weakness	
Chills				Joint Pain	
Night Sweats		Nausea/Vomiting		Muscle Pain	
Weight Loss		Diarrhea		Neck Pain	
Weight Gain		Constipation		Back Pain	
Fatigue		Abdominal Pain		Numbness/Tingling	
Swollen Glands		Trouble Swallowing		Difficulty Walking	
		Heartburn			
Vision Problems		Bloody/Black Stools		Fainting Spells	
Eye Pain		Hemorrhoids		Headaches	
Ringing in Ears		Loss of Appetite		Dizziness	
Ear Pain				Seizures	
Hearing Problems		Pain with Urination			
Nosebleeds		Blood in Urine		Depression/Anxiety	
Sinus Pain/Drainage		Urgency to Urinate		Sleeping Difficulty	
Sore Throat		Urinating 2x Per Night		Memory Problems	
		Incontinence		Suicidal Thoughts	
Chest Pain				Concentration Difficulty	
Palpitations		Rashes/Hives			
Irregular Heartbeat		Nail Fungus		Infertility	
Leg Swelling		Changing Mole		Vaginal Discharge	
Varicose Veins				Breast Pain	
Snoring		Excessive Thirst		Breast Lumps	
Shortness of Breath		Excessive Hunger		Erectile Dysfunction	
Cough		Heat/cold Intolerance			

Year of last test	Prostate (Males)	Colonoscopy	Cardiac Stress Test
	TB Test	Eye Exam	Dental Exam
	Bone Density	Mammogram	Pap Smear

Date of last vaccine	**Flu:**	**Tetanus:**	**Pneumonia:**	**Shingles:**

☐**Married** ☐**Single** ☐**Widowed** ☐**Divorced**		**# of children:**
Concerns about safety or abuse at home? Yes / No		**Occupation:**
Alcohol:(amount/type/frequency)	**Coffee/Tea/Caffeine:** (cups/day)	**Smoking:** ☐No ☐Current ☐Past/Quit Packs/day _____ # of yrs _____

Females				
Menstrual flow: Regular / Irregular / Heavy		Days of flow:	Days between menses:	
1st day of last cycle:	Number of pregnancies:	Number of live births:	Number of abortions:	Number of Miscarriages:
Pain after sex: ☐Yes ☐No	Birth control: ☐Yes ☐No	Type of birth control:	Name of Birth control:	

List any other physicians that you see and their specialty:

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Name:_____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email Address: _____Marital Status: _____Gender: M / F

Insurance Information:
Why do we ask for this? While we do not bill your insurance for our services, it is important that we know what your insurance coverage is to help make sure we refer you to services that are within your network. If you do not have insurance, just leave this section blank.

Insurance Company: _____

Policy Number: _____ Group Number: _____

Pharmacy Info:

Local Pharmacy Name: _____ Phone Number: _____

Location: _____

Mail Order Pharmacy Name: _____

Confidential Communication (Please check one):

☐ I give permission for Milepost Medical to release medical information (or leave a message) to the following person(s):

Name: _____Phone #: _____Relationship: _____

Name: _____Phone #: _____Relationship: _____

☐ I do not give permission for Milepost Medical to release information to anyone other than to myself.

In case of emergency, please let us know whom we may contact:

Name: _____Phone #: _____Relationship: _____

Name: _____Phone #: _____Relationship: _____

Name: _____Phone #: _____Relationship: _____

How did you hear about us?
☐Family/Friend ☐Internet ☐Facebook ☐Flyer ☐Other_____
☐Physician Referral_____