Dirk R. Diefendorf, M.D.
ORTHOPEDIC SURGERY - SPORTS MEDICINE

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Age _____ Date _____

Past Medical History

Cardiac:
Chest Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Other _____

Respiratory:
- ☐ Cough
- ☐ Asthma
- ☐ COPD
- ☐ Other _____

Digestive:
- ☐ Gastroesophageal Reflux
- ☐ Peptic Ulcer Disease
- ☐ Liver Disease
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ Other _____

Urinary:
- ☐ Prostate Enlargement
- ☐ Kidney Stones
- ☐ Urinary Infections
- ☐ Kidney Failure
- ☐ Other _____

Endocrine:
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Osteoporosis
- ☐ Steroids
- ☐ Other _____

Hematologic:
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Transfusions
- ☐ Cancer – What kind? _____

Vision:
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Other _____

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Eating Disorder
- ☐ Other _____

Muscular:
- ☐ Back pain
- ☐ Arthritis
- ☐ Other _____

Allergies (please list)
_____
_____
_____

Medications (Please list with doses)
_____
_____
_____
_____
_____
_____

Surgical History (Please list with dates)
_____
_____
_____
_____
_____

Social History
Do you smoke tobacco? YES☐ NO☐
If so, how much? _____
Do you drink alcohol? YES☐ NO☐
If so, how much? _____
What is your occupation? _____
Whom do you live with? _____

Family History
Mother (Check one) Living☐ Deceased☐ Age_____
Medical Problems _____

Father (Check one) Living☐ Deceased☐ Age_____
Medical Problems _____

Any relatives with the following

Colon Cancer	YES☐	NO☐	Who? _____
Breast Cancer	YES☐	NO☐	Who? _____
Prostate Cancer	YES☐	NO☐	Who? _____
Heart Problems	YES☐	NO☐	Who? _____