MARK T. KOWAL, M.D., P.C.
Medical History Questionnaire

Date_____

Patient Name_____ Date of Birth_____ Age_____

Reason for office visit_____

Have you been treated for this previously? _____

Height _____Weight _____ Preferred Pharmacy _____

Circle answers below:

- Marital Status: Single Married Other
- Use of Alcohol: Never Rarely Moderate Daily
- Use of Tobacco: Never Previously but quit Current user/Frequency_____
- Use of Illicit Drugs: Never Type/Frequency_____

Primary Care Physician_____

Referring Physician_____

List names and dosages of all current medications:

_____

_____

_____

_____

_____

_____

List any known drug allergies:

_____

_____

Indicate previous surgeries and dates:

Gallbladder_____
Appendectomy_____
Eye or Cataract_____
Orthopedic_____
Ulcers_____
Thyroid_____
Tonsillectomy_____
Hysterectomy_____

Heart_____
Lung_____
Hernia_____
Breast_____
Colon/Stomach_____
Colonoscopy_____
EGD_____
Other_____

Have you had any of the following conditions?

Cancer _____Yes/No
Arthritis/Gout_____ Yes/No
Acute Infection _____ Yes/No
Diabetes _____ Yes/No
Stroke_____ Yes/No
Heart trouble_____ Yes/No

Convulsions/Seizures_____ Yes/No
Venereal disease _____Yes/No
Hypertension _____Yes/No
Bleeding tendency _____Yes/No
Hereditary defects_____ Yes/No
Sleep apnea _____ Yes/No

Family Medical History: List medical problems and ages of parents, siblings, and children. If deceased, please list cause of death. List any major medical problems in the family.

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