ADULT MEDICAL HISTORY QUESTIONNAIRE

Check/update this form prior to going offshore. Provide in sealed envelope to the captain or M.O. for emergencies prior to sailing.

Date: _____

Patient Name: _____ Please Print Last First	DOB:____/____/____ Gender :	Age: _____ ☐ Male ☐ Female
Chief Complaint: _____		
Mechanism of Injury: _____		

Emergency Contact Ashore	Name:_____ Address:_____	Phone:_____ Cell:_____
Primary Care Provider:_____ Doctor who sent you here:_____		

PAST MEDICAL HISTORY

☐ ADD ☐ Anemia ☐ Anesthesia Problems ☐ Arthritis ☐ Asthma ☐ Bleeding Disorders ☐ Cancer (skin, thyroid, etc) Type:_____ ☐ Depression/Anxiety ☐ Diabetes, Type I	☐ Diabetes, Type II ☐ Dizziness ☐ Environmental Allergies ☐ Food Allergies ☐ Gastric Reflux ☐ Headaches ☐ Hearing Loss ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol	☐ High Lipids ☐ HIV ☐ Hoarseness ☐ Insomnia ☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease ☐ Migraine Headaches ☐ Nasal Obstruction ☐ Restless Leg Syndrome	☐ Sleep Apnea ☐ Prior Sleep Study When:_____ Where:_____ ☐ Snoring ☐ Stomach Ulcer ☐ Stroke ☐ Thyroid Disease ☐ TMJ Disorder ☐ Vascular Stents
☐ Vascular Stents	☐ Other:_____		

PAST SURGICAL HISTORY

☐ Ear Surgery ☐ Facial Surgery ☐ Nasal/Sinus Surgery	☐ Neck Surgery (ie thyroid) ☐ Skin Lesion/Cancer Surgery ☐ Tonsillectomy/Adenoidectomy	☐ Vocal Cord Surgery
☐ Other:_____		

CURRENT MEDICATIONS

List any current or recent medications taken including dosages:	_____ _____ _____
☐ No medications	

DRUG ALLERGIES

Drug Allergies:	☐ No Known Drug Allergies	☐ Yes (if yes, please list and include reaction)

CURRENT MEDICATIONS

Alcohol Usage	Tobacco Usage	Other
☐ Currently Every Day Amount: _____ Type: _____ ☐ Currently Some Days Amount: _____ Type: _____ ☐ Former Age Quit: _____ ☐ Never	☐ Currently Every Day Amount: _____ Type: _____ ☐ Currently Some Days Amount: _____ Type: _____ ☐ Former Age Quit: _____ ☐ Never	☐ Do you live alone? (check for yes) ☐ Prior or Current Recreational Drug Use ☐ Other Risk Factors for HIV Explain: _____ Occupation: _____

REVIEW OF SYSTEMS

Please check all symptoms which you have presently or have had recently. If you have not experienced a medical problem under the symptom listed, check the No box.

CONSTITUTIONAL SYMPTOMS

☐fatigue ☐fever ☐difficulty sleeping
Other:

☐No Constitutional Symptoms

NEUROLOGIC SYMPTOMS

☐speech difficulties ☐migraines ☐dizziness ☐headaches ☐seizures ☐numbness/tingling ☐weakness
Other:

☐ No Neurologic Symptoms

EYE SYMPTOMS

☐eye discomfort ☐changes in vision
Other:

☐No Eye Symptoms

MUSCULOSKELETAL SYMPTOMS

☐muscular weakness ☐twitching ☐gait changes ☐joint pain
Other:

☐No Musculoskeletal Symptoms

CARDIOVASCULAR SYMPTOMS

☐chest pain ☐irregular heart beats ☐lightheadedness
Other:

☐No Cardiovascular Symptoms

ENDOCRINE SYMPTOMS

☐weight gain ☐weight loss ☐history of thyroid problems ☐hot or cold intolerances
Other:

☐No Endocrine Symptoms

RESPIRATORY SYMPTOMS

☐shortness of breath ☐hoarseness ☐cough ☐wheezing
Other:

☐No Respiratory Symptoms

PSYCHIATRIC SYMPTOMS

☐anxiety ☐depression
Other:

☐No Psychiatric Symptoms

GASTROINTESTINAL SYMPTOMS		HEME(BLOOD)-LYMPH SYMPTOMS
☐nausea ☐heartburn ☐difficulty swallowing ☐choking on liquids ☐reflux Other:		☐swollen lymph nodes ☐easy bleeding or bruising Other:
☐No Gastrointestinal Symptoms		☐No Heme(blood)-Lymph Symptoms
GENITOURINARY SYMPTOMS		**ALLERGIC-IMMUNOLOGIC SYMPTOMS**
☐urgency ☐pain or burning with urination ☐urinary tract infection ☐kidney stones Other:		☐environmental allergies ☐immune deficiency Other:
☐No Genitourinary Symptoms		☐No Allergic-Immunological Symptoms
INTEGUMENT (SKIN) SYMPTOMS		
☐new skin lesions ☐lumps ☐change in mole appearance Other:		
☐Integument (skin) Symptoms		