Date: _____

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.

Patient Name: _____ DOB: / / Age: _____
Please Print Last First
Gender: □ Male □ Female

Chief Complaint: _____

Mechanism of Injury: _____

Emergency Contact Ashore

Name: _____ Phone: _____

Address: _____ 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
□ No Pertinent History
□ Other: _____

PAST SURGICAL HISTORY

Please include dates of surgery

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

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)

SOCIAL HISTORY

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

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

EYE SYMPTOMS

□ eye discomfort □ changes in vision

Other:

□ No Eye Symptoms

CARDIOVASCULAR SYMPTOMS

□ chest pain □ irregular heart beats
□ lightheadedness

Other:

□ No Cardiovascular Symptoms

RESPIRATORY SYMPTOMS

□ shortness of breath □ hoarseness □ cough
□ wheezing

Other:

□ No Respiratory Symptoms

GASTROINTESTINAL SYMPTOMS

□ nausea □ heartburn □ difficulty swallowing
□ choking on liquids □ reflux

Other:

□ No Gastrointestinal Symptoms

GENITOURINARY SYMPTOMS

□ urgency □ pain or burning with urination
□ urinary tract infection □ kidney stones

Other:

□ No Genitourinary Symptoms

INTEGUMENT (SKIN) SYMPTOMS

□ new skin lesions □ lumps □ change in mole appearance

Other:

□ No Integument (skin) Symptoms

NEUROLOGIC SYMPTOMS

□ speech difficulties □ migraines □ dizziness □ headaches
□ seizures □ numbness/tingling □ weakness

Other:

□ No Neurologic Symptoms

MUSCULOSKELETAL SYMPTOMS

□ muscular weakness □ twitching □ gait changes
□ joint pain

Other:

□ No Musculoskeletal Symptoms

ENDOCRINE SYMPTOMS

□ weight gain □ weight loss □ history of thyroid problems
□ hot or cold intolerances

Other:

□ No Endocrine Symptoms

PSYCHIATRIC SYMPTOMS

□ anxiety □ depression

Other:

□ No Psychiatric Symptoms

HEME(BLOOD)-LYMPH SYMPTOMS

□ swollen lymph nodes □ easy bleeding or bruising

Other:

□ No Heme(blood)-Lymph Symptoms

ALLERGIC-IMMUNOLOGIC SYMPTOMS

□ environmental allergies □ immune deficiency

Other:

□ No Allergic-Immunological Symptoms