Print Name:__________________ **Date**:______________

Medical Questionnaire

PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS

Do you have a history of:
Please circle all items

Y or N Asthma
Y or N Diabetes
Y or N Migraines
Y or N Heart Disease
Y or N High Blood Pressure
Y or N Epilepsy
Y or N Seizures
Y or N Kidney Disease
Y or N Phlebitis “blood clots”
Y or N Blood Transfusion
Y or N Thyroid disease
Y or N Wound healing problems
Y or N Anemia
Y or N Steroids/Prednisone
Y or N Stroke
Y or N Hepatitis

Y or N Diet Pills/Herbal Supplements: Type______________
Y or N Mammogram: When_______ Physician________________
Y or N MRSA/Staph: When________Treatment________________
Y or N Pain Medication Dependency: Type________Treatment________________
Y or N Psychiatric Illnesses: Type_________Treatment________________

Hospitalization/Surgeries:

Date **Type of Surgery** **Place of Surgery** **Physician**

1. ____
2. ____
3. ____
4. ____
5. ____

If more, please list on back of sheet

Family History of:
Please check all that apply:

(___Heart Disease; relationship______) (___Diabetes; relationship_______)
(___Cancer; relationship________)(____Other not listed___________; relationship_______)

Do you: Smoke: Y or N, How much _________________
Use Alcohol: Y or N, How often_______________
Use Recreational drugs: Y or N Type_______________
Walk with a walker or cane: Y or N _______________

Current Medications: ***over the counter, herbal, nutritional, etc*.**

Medication Name:	Dose:	Frequency:	Last Dose Taken:

If more, please list on back of sheet

Allergies: ____

____

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