

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 | Phlebitis "blood clots" |
| Y or N | Diabetes | Y or N | Blood Transfusion |
| Y or N | Migraines | Y or N | Thyroid disease |
| Y or N | Heart Disease | Y or N | Wound healing problems |
| Y or N | High Blood Pressure | Y or N | Anemia |
| Y or N | Epilepsy | Y or N | Steroids/Prednisone |
| Y or N | Seizures | Y or N | Stroke |
| Y or N | Kidney Disease | 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: _____
