Name ____________________ **Date___________**

Medical History Questionnaire

Please complete this medical history form to the best of your ability. If you need assistance, ask the assistant that brings you to the exam room for help. Please print clearly.

Allergies?

Medication	Reaction	Medication	Reaction
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

If more space is needed, please continue list on back of page.

Medications

Name	Dose	Frequency	Name	Dose	Frequency

If more space is needed, please continue list on back of page.

Herbal Supplements?

Please list any herbal supplements that you take.

____

____

Medical History and Review of Systems

General symptoms

- ☐ Weight gain _____ lbs
- ☐ Weight loss _____ lbs
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats

Ear, Nose Throat

- ☐ Hearing loss
- ☐ Visual problems
- ☐ Headache

Cardiovascular System

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Chest pain
- ☐ Arrhythmia
- ☐ Circulation problems
- ☐ High cholesterol
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Other ________________

Pulmonary Disease

- ☐ Shortness of breath
- ☐ Asthma
- ☐ Emphysema
- ☐ Other ________________

Gastrointestinal Disease

- ☐ Diarrhea
- ☐ Constipation
- ☐ Hepatitis **A B C** (circle one)
- ☐ Ulcers, acid reflux, GERD

Urinary Disorders

- ☐ Incontinence Stress?
- ☐ Prostate
- ☐ Other ________________

Skin

- ☐ Psoriasis
- ☐ Eczema

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disease

Neuro/Psych

- ☐ Stroke
- ☐ Seizure
- ☐ Depression
- ☐ Anxiety
- ☐ Other ________________

Musculoskeletel

- ☐ Arthritis/Rheumatism
- ☐ Gout
- ☐ Osteoporosis
- ☐ Fractures ____________

____

____

____

Cancer ________________

____

____

____

____

Name ____________________________ **Date**______________

Past Surgical History

Procedure	Date	Procedure	Date

If more space is needed, please continue list on back of page.

Family History

	Father	Mother	Siblings
Deceased?	☐	☐	☐
Alcoholism	☐	☐	☐
Asthma	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
Heart failure	☐	☐	☐
High Blood Pressure	☐	☐	☐
Mental Illness	☐	☐	☐
Osteoporosis	☐	☐	☐
Stroke	☐	☐	☐
Thyroid Disease	☐	☐	☐

Other ____

Surgical Risks

Latex Allergy ? ☐ Yes ☐ No

Blood Transfusion? ☐ Yes ☐ No
Reaction ? ☐ Yes ☐ No

Reaction to Anesthesia ?
Personal ☐Yes ☐ No
Family ☐Yes ☐ No

History of Blood Clots ?
Legs ☐Yes ☐ No
Lungs ☐Yes ☐ No

Social History

Tobacco: Cigarettes _____ packs/day _____ yrs Alcohol: Type _______ amnt/freq ________

Recreational drugs Yes No Type? ______________________________

Living Situation (Circle answer) Home Other ____________________________ Family Alone

Occupation ___________________________ **Employer** _________________________________
Working? Yes No **Last Date Worked** ______________________________________
Education: Highest level of education completed ____
Sports/Hobbies ____

By signing this form, I certify the information provided is accurate and correct to the best of my knowledge.

Signature ____**Date** _____________________