

MEDICAL QUESTIONNAIRE

Today's date: _____ Date of birth: _____

Name: _____ Gender: M __ F __

Reason for today's visit: _____

CURRENT MEDICATIONS

Please list any medications you are currently taking (include prescription, non-prescription, vitamins, supplements, herbals, etc.)

MEDICAL HISTORY

Check any of the following medical problems you have currently or in the past:

- | | | |
|---|---|---|
| <input type="checkbox"/> Acid reflux/heartburn | <input type="checkbox"/> Enlarged prostate in men | <input type="checkbox"/> Kidney disease or stones |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eye problem/glaucoma | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia or blood problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Reproductive system problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing/ear problems | <input type="checkbox"/> Sexually transmitted infection |
| <input type="checkbox"/> Back/spine problems | <input type="checkbox"/> Heart disease/chest pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Heart palpitations/murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Swelling of legs/feet |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Constipation or diarrhea | <input type="checkbox"/> Hepatitis or liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dementia/memory loss | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers/intestinal problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular heart beat | |
| | <input type="checkbox"/> Lung/breathing problems | |

ALLERGIES

List any allergies to medications, x-ray dyes, or other substances

FAMILY HISTORY

Have your parents, grandparents, siblings or children ever had any of the following medical problems?

	Family Member
___ Diabetes	_____
___ High blood pressure	_____
___ Heart disease	_____
___ Stroke	_____
Mental Illness (anxiety, depression, etc)	_____
___ Cancer	_____
___ Blood clots	_____
___ Other:	_____

SOCIAL HISTORY

Do you currently smoke? Yes___ No___

If yes, how many packs per day? _____

Are you a former smoker? Yes___ No___

If yes, when did you quit smoking? _____

Do you drink alcohol? Yes___ No___

If yes, how often and how many drinks? _____

Have you used recreational drugs? Yes___ No___

If yes, please explain: _____