

CONFIDENTIAL INFORMATION: This information will not be released except by your authorization. This form is used to obtain your complete medical history.

Name: _____ Date: _____
Age: _____ Height: _____ Weight: _____

MEDICAL QUESTIONNAIRE

PERSONAL HISTORY

Do you have, or have you ever had, any of the following?
Please circle your answer.

- Thyroid YES NO
- Tuberculosis..... YES NO
- Glaucoma YES NO
- Cancer YES NO
- Diabetes..... YES NO
- Pneumonia YES NO
- Asthma YES NO
- Emphysema..... YES NO
- Rheumatic Fever YES NO
- High Blood Pressure YES NO
- Heart Disease..... YES NO
- Phlebitis..... YES NO
- Ulcer YES NO
- Venereal Disease..... YES NO
- Jaundice or Hepatitis..... YES NO
- Gall Bladder Disease..... YES NO
- Colitis YES NO
- Kidney Disease YES NO
- Kidney Stones..... YES NO
- Epilepsy..... YES NO
- Severe Allergic Diseases..... YES NO
- Bleeding Disorder..... YES NO
- Any other Diseases..... YES NO

SURGERY

Have you had any operations?YES NO
If yes, please list:

HOSPITALIZATIONS

Have you ever been hospitalized for
medical illness?.....YES NO
If yes, please list:

HABITS

Please circle your answer.

- Have you been a smoker?.....YES NO
- Do you drink alcohol?YES NO
- Do you drink coffee?.....YES NO
If yes, how many cups per day? _____
- Do you exercise regularly?YES NO
If yes, describe briefly:

MEDICATIONS

Please list all medications you are taking.

_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____

Please list any drug allergies:

Latex Allergy YES NO

What is the reason you are here today? _____

Due to the large volume of lab work and tests which are obtained daily, we will attempt to contact you with your lab values. However, ultimately you are responsible for calling our office for laboratory results.

Signature