MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

GENDER M F OTHER NAME: _____

DOB: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

_____ YOUR FAMILY DOCTOR:

HOME PHONE: _____ _____

CELL PHONE: _____ PHONE: _____

EMAIL: _____ DATE OF LAST MED EXAM: _____

HOW DID YOU HEAR ABOUT US?

FACEBOOK GOOGLE SIGNS LIVE NEAR BY MAIL FLYER OTHER: _____

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? YES ☐ NO ☐ NOT SURE/MAYBE ☐

   _____

2. Has there been any change in your general health in the past year? If yes, please explain.
   YES ☐ NO ☐ NOT SURE/MAYBE ☐

   _____

3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. YES ☐ NO ☐ NOT SURE/MAYBE ☐

   _____

4. Do you have any allergies? If yes, please list using the categories below:
   a) Antibiotics b) Penicillin c) Sulfa d) Codeine e) other (e.g. hay fever/foods)

5. Have you ever had a peculiar or adverse reaction to any medications or injections? Please explain. YES ☐ NO ☐ NOT SURE/MAYBE ☐

   _____

6. Do you have or have you ever had asthma? YES ☐ NO ☐ NOT SURE/MAYBE ☐
7. Do you have or have you ever had any kind of blood pressure problems?
   YES ☐ NO ☐ NOT SURE/MAYBE ☐

8. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or heart transplant? YES ☐ NO ☐ NOT SURE/MAYBE ☐
9. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, Aids, HIV infections, radiotherapy, or chemotherapy? YES ☐ NO ☐ NOT SURE/MAYBE ☐
10. Have you ever had hepatitis, jaundice or liver disease? YES ☐ NO ☐ NOT SURE/MAYBE ☐
11. Do you have a bleeding problem, bleeding disorder or are you on blood thinners? YES ☐ NO ☐ NOT SURE/MAYBE ☐
12. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. YES ☐ NO ☐ NOT SURE/MAYBE ☐

_____

13. Do you or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ heart attack	☐ stroke	☐ shortness of breath
☐ rheumatic fever	☐ pacemaker	☐ heart murmur	☐ mitral valve prolapse
☐ lung disease	☐tuberculosis	☐ cancer	☐ steroid therapy
☐ diabetes	☐ arthritis	☐ stomach ulcers	☐ seizures (epilepsy)
☐ kidney disease	☐ osteoporosis medications (Fosamax)		☐ drug/alcohol dependency

14. Are there any conditions or diseases not listed above that you have or have had? If so, what? YES ☐ NO ☐ NOT SURE/MAYBE ☐

_____

15. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? YES ☐ NO ☐ NOT SURE/MAYBE ☐

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

DATE: _____