

Medical Questionnaire

Date: _____

Name: _____ Gender: Male Female Age: _____
Last First Middle

Birth-date: _____ Birth Place: _____ Mother's Birth Name: _____

Social Security #: _____ - _____ - _____ Driver's License #: _____

Marital Status: Single Married – Spouse's Name _____

Married how long? _____ Divorced Separated Widowed

Language Spoken: _____ Interpreter Required? Yes No

Home Address: _____

City: _____ State: _____ Zip-code: _____ - _____

Phone: _____ Fax: _____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip-code: _____ - _____ Fax: _____

Emergency Contact: _____ Relationship: _____
 (Not living in the same household)

Address: _____

City: _____ State: _____ Zip-code: _____ Fax: _____

Local Telephone Number: (Relative, Friend or Hotel) _____

1. Referring Physician: _____
 Specialty: _____
 Address: _____
 City: _____ State: _____ Zip-code: _____ - _____
 Phone: _____ Fax: _____
 Send periodic report*

2. Other Physician: _____
 Specialty: _____
 Address: _____
 City: _____ State: _____ Zip-code: _____ - _____
 Phone: _____ Fax: _____
 Send periodic report*

3. Other Physician: _____
 Specialty: _____
 Address: _____
 City: _____ State: _____ Zip-code: _____ - _____
 Phone: _____ Fax: _____
 Send periodic report*

* Periodic reports may be sent to your physician(s). Please check box of any physician you wish to receive reports.

Patient Name: _____ Date of Birth: _____ Date: _____

Height: _____ Weight: _____ SS #: _____ - _____ Spouse's Name: _____

Allergies

Category	Yes	No	Do Not Know	List Allergies	Explain Reaction
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Environmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Medical History:

<input type="checkbox"/> Bleeding	<input type="checkbox"/> Dizziness / Fainting	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Edema	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Bone Disorder	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pain	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Chipped / Loose Teeth	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pulmonary Disease	<input type="checkbox"/> Personal History of Anesthesia problems
<input type="checkbox"/> Dentures	<input type="checkbox"/> Implanted Device (Shunt, Pump, Pacemaker)	<input type="checkbox"/> Seizures	<input type="checkbox"/> Family History of Anesthesia problems
<input type="checkbox"/> Diabetes	**For Women: Date of Last Menstrual Period (LMP): _____		

Please list and describe any previous Hospitalization and / or Surgeries:

Have you or family members had a previous history of anesthesia problems? (Explain)

Do you: Smoke: Yes No Amount: _____

Consume Alcohol: Yes No Amount: _____

Medications

	Name of Medication	Dose	Frequency	Last Dose	Comments
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Patient Name: _____

Please indicate if you have had or currently are experiencing any of the following. If you are not sure, please mark "Do Not Know" and we will be happy to assist you during your scheduled visit.

GENERAL

	Condition	Yes	No	Do Not Know
1.	Swollen or enlarged (lymph) glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Other tumors or cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEAD, EYES, EARS, NOSE, THROAT – (HEENT)

	Condition	Yes	No	Do Not Know
1.	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Eye injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Blurring vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Earaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Ringling or buzzing in ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Decrease / loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Sensation of spinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Unusual trouble with teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Skin tumors / moles removed or burned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Chronic or frequent infections, colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____

ENDOCRINE

	Condition	Yes	No	Do Not Know
1.	Thyroid trouble or goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Thyroid medication or tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Frequent Laryngitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Hoarseness or change in voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BREAST

	Condition	Yes	No	Do Not Know
1.	Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEART

	Condition	Yes	No	Do Not Know
1.	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Bleeding tendency or easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Pain or pressure in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Undue shortness in breath (day or night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Pain in legs while walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Fast or irregular heart beating (palpitations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Heart murmurs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PULMONARY

	Condition	Yes	No	Do Not Know
1.	Chronic cough, coughed up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have the date of your last chest x-ray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Soaking sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Exposure to TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____

GASTROINTESTINAL

	Condition	Yes	No	Do Not Know
1.	Stomach, liver or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Recent gain or loss of weight. (lbs.) Gain _____ Loss _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Frequent bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Recent change in bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Black bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY URINARY

	Condition	Yes	No	Do Not Know
1.	Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Frequent or painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Sugar or albumin in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Slow starting of urine stream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Passing urine at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL

	Condition	Yes	No	Do Not Know
1.	Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Back or bone pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Clumsiness / awkwardness of hands / feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Numbness or tingling of hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Muscle pain or weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGIC

	Condition	Yes	No	Do Not Know
1.	Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Reactions to serum, drug or medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Excessive worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Excessive depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Sexual impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Strokes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____

Women Only

GYNECOLOGICAL

	Condition	Yes	No	Do Not Know
1.	Vaginal bleeding following intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Irregular or excessive menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Been treated for female disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you used an intrauterine device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you gone through menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any past breast problems:

Are you taking hormones: Yes No _____

Have you ever taken birth control pills or hormones? Yes No

Type: _____ How long? _____

When stopped? _____

Age of onset of menstruation: _____

Interval between periods: _____

Date of last period: _____

Number of pregnancies: _____

Number of births: _____

Number of abortions: _____

Your age at birth of your first child: _____

Family history of breast problems _____

Date of your Last Menstrual Cycle (LMC): _____

Patient Name: _____

Past Surgeries (Operations):

Please list in chronological order

DATE	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

Other Hospitalizations:

Please list in chronological order

DATE	TYPE	HOSPITAL	DOCTOR

Radiation Therapy Treatment:

Please list in chronological order.

We need to know when treatment started and when it was completed.

STARTED?		STOPPED?		AREA OF BODY TREATED	HOSPITAL	DOCTOR
Month	Year	Month	Year			

Patient Name: _____

Family History

RELATION	AGE	STATE OF HEALTH	IF DECEASED – CAUSE OF DEATH	AGE AT DEATH
Father				
Mother				
Spouse				
Brothers				
Sisters				
Children				

Patient Name: _____

Have any of your *blood* relatives, husband, wife or children had any of the following?

Yes	No	(CHECK EACH ITEM)	RELATION(S)
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Hay Fever, Other Allergy	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Arthritis (Rheumatism)	
<input type="checkbox"/>	<input type="checkbox"/>	Nervous Or Mental Disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Goiter	
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	
<input type="checkbox"/>	<input type="checkbox"/>	Any Other Illness	