Patient Medical History Questionnaire

Label

PLEASE CHECK ALL THAT APPLY

Medical History

- ❑ Asthma
- ❑ Diabetes
- ❑ Seizure
- ❑ Bleeding Problems
- ❑ Emphysema
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Liver Problems
- ❑ Tuberculosis
- ❑ Cancer:
  Type:________________
  ____
  ____
- ❑ Ulcers
- ❑ Alcohol Abuse
- ❑ Marijuana/street drugs
- ❑ Hepatitis
- ❑ Hyperlipidemia
- ❑ Depression/anxiety
- ❑ Hypothyroidism
- ❑ Other: ______________
  ____

Surgical History

- ❑ Brain
- ❑ Back
- ❑ Neck
- ❑ Gall Bladder
- ❑ Heart
- ❑ Carpal Tunnel
- ❑ Hemorrhoid
- ❑ Hernia
- ❑ Hysterectomy
- ❑ Prostate
- ❑ Tonsils/Adenoids
- ❑ Hip L R
- ❑ Shoulder L R
- ❑ Knee L R
- ❑ Other___________
  ____
  ____

Family Medical History

Please specify cancer, heart disease, etc.

Father: ________________
____
____
____

Mother:________________
____
____
____

Siblings: _______________
____
____

Last Known Tetanus

Allergies	Reactions

Present Medications

____
____
____
____
____

❑ List attached

Personal Data:

Height:_______ Ft. ________ In. Weight: _______ lbs.

Alcohol Use: ❑ Daily ❑ Weekly ❑ Occasional ❑ Never

Smoke: ❑ Yes ____ packs per day ❑ Never

Seatbelts: ❑ Always ❑ Usually ❑ Never

Employment:

❑ Full Time ❑ Part Time ❑ Unemployed ❑ Retired

Prior/Current Occupation: _________________________

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