

Medical History Questionnaire

Full Legal Patient Name _____

Primary Language Spoken _____ Date of Birth _____ Age _____

Primary Care Physician _____

Reason for visit _____

DRUG ALLERGIES _____

Food? _____ Latex? _____

Please list **All** current medication taken _____

LAST TETANUS SHOT? _____ (Women) Last Menstrual Period _____

<i>Past Medical History</i>	<i>(Circle)</i>	<i>Past Surgical History</i>	<i>Date</i>
<i>None</i>		<i>None</i>	
<i>High Blood Pressure</i>	<i>Strokes</i>	<i>Open Heart</i>	
<i>Diabetes</i>	<i>Asthma</i>	<i>Angioplasty</i>	
<i>Chronic Bronchitis</i>	<i>Cardiac Disease</i>	<i>Gall Bladder</i>	
<i>Emphysema</i>		<i>Back or Knee</i>	
<i>Seizures</i>		<i>Appendectomy</i>	
<i>Other</i>		<i>Other</i>	

Social History

Do you smoke? _____ If yes, How much and how many years? _____

Do you drink Alcohol? _____ If yes, How much per week? _____

Do you take drugs not prescribed to you? _____

Family History

(Please circle)

Diabetes *Coronary Artery Disease* *Cancer (type)* _____

Stroke *High Blood Pressure* *Other* _____ *None*

(Please Check one box below)

May we contact you regarding your visit by phone? Yes _____ *No* _____

Preferred contact phone number _____

I do not wish to have my medical information released to me by phone.

Signed: _____ *Date:* _____

How did you hear about us? (Please circle one) *Postcard* *In Health TV Station* *Newspaper* *Doctor* *Friend*
Website *Phone Book* *Brochure* *Other* _____