Name: ______________________________ **Date:**________________

Referred by: _________________________ **D.O.B.:**_______________

Medical Questionnaire – Please Complete ALL Sections

Medical Conditions & Surgeries

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Allergies to Medications

1. ______________________________
2. ______________________________
3. ______________________________
3. ______________________________

Doctors I Currently See

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Medications I Take

Name: **Dose** **Frequency**

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________
14. ______________________________

Marital Status: ___________________________
Alcohol Use (how much): ___________________________
Tobacco Use (how much): ___________________________
Drug Use (how much): _________________________ **Other:** _________________________

Constitutional			Ears/Nose/Mouth/Throat			Eyes		
Good General Health	Yes	No	Hearing loss or ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent Weight Change	Yes	No	Sinus problems	Yes	No	Blurred/double vision	Yes	No
Night Sweats, fevers	Yes	No	Nose bleeds	Yes	No	Eye disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice change	Yes	No	Glaucoma	Yes	No
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest Pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart Trouble	Yes	No	Wheezing/Asthma	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No
Musculoskeletal			**Neurological**			**Integumentary (Skin/Breast)**		
Muscle pain or cramps	Yes	No	Frequent headaches	Yes	No	Change in hair or nails	Yes	No
Stiffness/swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Convulsions/seizures	Yes	No	Breast lump	Yes	No
Trouble walking	Yes	No	Numbness/tingling	Yes	No	Breast pain or discharge	Yes	No
Endocrine			**Hematologic/Lymphatic**			**Allergic/Immunologic**		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food allergies	Yes	No
Thyroid disease	Yes	No	Slow to heal	Yes	No	Aspirin allergies	Yes	No
Hormone problem	Yes	No	Enlarged glands	Yes	No	Antibiotic allergies	Yes	No
Genitourinary-Male Only			**Genitourinary- Female only**			**Psychiatric**		
Blood in urine	Yes	No	Blood in urine	Yes	No	Insomnia	Yes	No
Kidney stones	Yes	No	Kidney stones	Yes	No	Confusion/memory loss	Yes	No
Sexual problems	Yes	No	Sexual problems	Yes	No	Depression	Yes	No
Testicle pain	Yes	No	Menstrual problems	Yes	No			

For Office Use Only Check the entry furthest to the right for ROS	None	Pertinent 1 System	Extended 2-9 Systems	Complete 10 systems or some Systems w/all others negative

PATIENT STATEMENT:

To the best of my knowledge, the above information is accurate and complete.

Patient signature ______________________ **Date** ______________________

Notes:

Physician Statement: I have reviewed the questionnaire with the patient.

Physician Signature ______________________ Date ______________________

PATIENT NAME: ______________________ D.O.B.:______________ Date:______________