

# Medical History Questionnaire

NAME OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_  
Last First M. I.

PLEASE STATE THE **REASON FOR THIS VISIT**, AND LIST ANY SYMPTOMS THAT CONCERN YOU:

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WHAT TREATMENTS HAVE YOU TRIED FOR THIS PROBLEM?

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WHAT TESTS HAVE YOU HAD FOR THIS PROBLEM? (X-RAYS, CT OR MRI SCANS, HEARING TESTS, ETC.)

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ARE YOU TAKING ANY MEDICATIONS?  YES  NO IF "YES", PLEASE LIST THEM BELOW:

CURRENT MEDICATIONS (prescription & non-.)	STRENGTH (mg)	SCHEDULE (How many & times per day)

PLEASE LIST ANY **MEDICAL CONDITIONS** YOU ARE CURRENTLY RECEIVING TREATMENT FOR (such as high blood pressure, diabetes, asthma, allergy, etc.): \_\_\_\_\_

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WHAT **SURGERIES OR HOSPITALIZATIONS** HAVE YOU HAD IN THE PAST FIVE YEARS? \_\_\_\_\_

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HAVE YOU EVER BEEN TREATED FOR CANCER? EXPLAIN: \_\_\_\_\_

DO YOU HAVE ANY **MEDICAL ALLERGIES**?  YES  NO IF "YES", PLEASE LIST THE MEDICATIONS:

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ARE YOU CURRENTLY **SMOKING**?  YES  NO IF "YES", HOW MUCH DO YOU SMOKE? \_\_\_\_\_

DID YOU EVER SMOKE?  YES  NO IF "YES", PLEASE EXPLAIN WHEN YOU STARTED, WHEN YOU QUIT, AND

HOW MUCH YOU SMOKED: \_\_\_\_\_

HOW MUCH **ALCOHOL** DO YOU CONSUME? \_\_\_\_\_