MEDICAL QUESTIONNAIRE

Patient _____ Date _____

Do you have any allergies to medications? YES ☐ NO ☐

If yes, which medications? _____

_____

_____

_____

WEIGHT _____ HEIGHT _____

Do you have any medical problems?

Diabetes YES ☐ NO ☐

Hypertension YES ☐ NO ☐

Heart Disease YES ☐ NO ☐

Peptic Ulcer Disease YES ☐ NO ☐

When was your last check?

Mammography _____

Colonoscopy _____

Pap Smear _____

Please list your medications:

_____

_____

Have you ever had surgery? YES ☐ NO ☐

Date _____ Operation _____

Date _____ Operation _____

Have you ever been involved in a previous accident with injuries? Yes ☐ No ☐

Date _____ Injury _____ Work related? _____

Date _____ Injury _____ Work related? _____

Do you smoke? YES ☐ NO ☐

If yes, how much? _____ How long? _____

Do you drink alcohol? YES ☐ NO ☐

If yes, how much? _____