Patient's Name: _____

MEDICAL HISTORY QUESTIONNAIRE

Personal Physician: _____

Doctor's Phone No.: _____ Today's Date: _____

Patient's Age: _____ Patient's Occupation: _____ Height: _____ Weight: _____

A. Your Past Medical History: (Please complete the following regarding your current and past health.)

Yes	No	Have You Had?	Year	Comments
		Heart Disease		
		Heart Attack		
		High Blood Pressure		
		Stroke		
		Angina		
		Rheumatic Fever		
		Pneumonia		
		Tuberculosis		
		Asthma		
		Emphysema		
		Kidney Disease		
		Sugar Diabetes		
		Stomach Disorder		
		Ulcers		

Yes	No	Have You Had?	Year	Comments
		Liver Disease		
		Hepatitis		
		Anemia		
		Blood Clots		
		Thyroid Disease		
		Poor Circulation		
		Cancer		
		Arthritis		
		Lupus / Scleroderma		
		Fibromyalgia		
		Seizures		
		Nervous Disorders		
		Head Injury		
		Frequent Infections		

Have you or has anyone in your family ever had a problem with general anesthesia? Yes No

B. Your Previous Surgeries

Type of Surgery	Year	Hospital and / or Surgeon	Outcome

C. Your Current Medications: (Prescription and over the counter)

Medication	Strength	How many times per day?	Medication	Strength	How many times per day?

D. Your Past Medications: (Any medications you have taken in the past 6 months)

_____

E. Your Drug Allergies:

Medication	Reaction (Hives, nausea, etc.)	Medication	Reaction (Hives, nausea, etc.)

Please Complete Other Side

F. Social History:

Yes	No		Please explain
		Sleep Well	
		Use Alcohol	
		Use Tobacco	

Date of last tetanus shot: _____

G. Family History: (have any relatives had the following illness?)

Yes	No	Illness	If yes, what relation?	Comments
		Diabetes		
		High Blood Pressure		
		Heart Disease		
		Kidney Disease		
		Stroke		
		Arthritis or Rheumatism		
		Goiter (thyroid disease)		
		Cancer		
		Tuberculosis		
		Seizures		
		Alcoholism		

H. Review Symptoms: (please check regarding the following symptoms during the last six months)

Yes	No	Symptoms	Comments
		Chest Pain	
		Shortness of breath	
		Irregular heartbeat	
		Diarrhea	
		Bright red blood in stools	
		Black or tarry stools	
		Heartburn	
		Nausea and/or vomiting	
		Painful urination	
		Bladder or Kidney Infections	
		Loss of appetite	
		Significant weight loss	
		Night chills or sweats	
		Depression	
		Dizziness	
		Blackouts	
		Headaches	
		Paralysis or weakness of an arm or leg	
		Hives or Rashes	
		Wounds which will not heal	

I. Your Signature: (or signature of parent or guardian)

X _____

Signature