MEDICAL H ISTORY
QUESTIONNAIRE

NAME____DATE__________________
Family doctor____________________________Referring doctor___________________________
Current Occupion___________________________Reason for your visit_________________________
List ALL medications and doses you are currently taking: ____________________________________
____
____
____
____

Do you have any allergies to any medications? ☐ YES ☐ NO If yes, please list: ____________________
____
Are you allergic to the contrast used for CT scans? ☐ YES ☐ NO If yes, what is your reaction?__________
Do you currently take blood thinners, i/e. Coumadin, ASA? ☐ YES ☐ NO

List all surgeries you have had: Year and by whom:
____
____
____
____
____
____

Do YOU currently have or been diagnosed For any of the following?

Condition		
Anemia	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Chronic Pain	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO
Hemorrhoids	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO
Lupus	☐ YES	☐ NO
Rectal Bleeding	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Thyroid Disease	☐ YES	☐ NO
Varicose Veins	☐ YES	☐ NO
High Cholesterol	☐ YES	☐ NO

Check all that apply:

☐ Asthma ☐ Hepatitis
☐ TB ☐ Pregnant
☐ Sleep Apnea ☐ History of DVT/Blood Clot
☐ HIV ☐ MRSA

Is there a family history of any of the following:

Condition			
Diabetes	☐ YES	☐ NO, Whom?	________
High Blood Pressure	☐ YES	☐ NO, Whom?	________
Arthritis	☐ YES	☐ NO, Whom?	________
Breast Cancer	☐ YES	☐ NO, Whom?	________
Colon Cancer	☐ YES	☐ NO, Whom?	________
Heart Disease	☐ YES	☐ NO, Whom?	________
Kidney Disease	☐ YES	☐ NO, Whom?	________
Stroke	☐ YES	☐ NO, Whom?	________
Thyroid Disease	☐ YES	☐ NO, Whom?	________
Other__________	☐ YES	☐ NO, Whom?	________

Do you take narcotic medication? ☐ YES ☐ NO Prescribed by whom? ___________________________
Do you drink alcohol? ☐ YES ☐ NO If yes, how much _________________________________
Do your currently smoke? ☐ YES ☐ NO History of smoking? ☐ YES ☐ NO
If yes, how long did you smoke? ___________When did you quit? ___________Pack per day? ____________