

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:

WHAT TREATMENTS HAVE YOU TRIED FOR THIS PROBLEM?

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

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.): _____

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

HAVE YOU EVER BEEN TREATED FOR CANCER? EXPLAIN: _____

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

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? _____