

## GENERAL MEDICAL QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ FAMILY PHYSICIAN: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

REASON FOR VISIT TODAY: \_\_\_\_\_

MEDICATION ALLERGIES: \_\_\_\_\_

PAST OPERATIONS: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

PAST ILLNESSES: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

PAST FRACTURES: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

PRESENT HISTORY: Height \_\_\_\_\_ Weight \_\_\_\_\_

DO YOU SMOKE? YES ( ) NO ( ) If yes, how much? \_\_\_\_\_

DO YOU USE ALCOHOL? YES ( ) NO ( ) If yes, how much? \_\_\_\_\_

DO YOU TAKE ASPIRIN? YES ( ) NO ( ) If yes, how much? \_\_\_\_\_

DO YOU TAKE ANTI-INFLAMMATORY MEDICATION? YES ( ) NO ( ) If yes, how much? \_\_\_\_\_

(If yes to above medication, for what diagnosis? \_\_\_\_\_)

### ANY HISTORY OF THE FOLLOWING:

Asthma	YES ( )	NO ( )	Lung Disease	YES ( )	NO ( )
Diabetes	YES ( )	NO ( )	Heart Disease	YES ( )	NO ( )
Bleeding Problems	YES ( )	NO ( )	Gout	YES ( )	NO ( )
Stomach/Ulcer Problems	YES ( )	NO ( )	Liver Disease	YES ( )	NO ( )
High Blood Pressure	YES ( )	NO ( )	Kidney Disease	YES ( )	NO ( )
Thyroid Disease	YES ( )	NO ( )	Glaucoma	YES ( )	NO ( )
Sleep Apnea	YES ( )	NO ( )	Other	YES ( )	NO ( )
Arthritis	YES ( )	NO ( )			

If yes, where? \_\_\_\_\_ If known, what type? \_\_\_\_\_

### LIST ANY FAMILY MEMBER WITH HISTORY OF HEART OR LUNG DISEASE, CANCER OR SERIOUS ILLNESS:

RELATIONSHIP: \_\_\_\_\_ TYPE: \_\_\_\_\_

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# MEDICAL HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PLACE AN (X) BEFORE ANY SYMPTOMS YOU HAVE NOW.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> fever, chills       | <input type="checkbox"/> palpitations           | <input type="checkbox"/> arthritis or joint pains     |
| <input type="checkbox"/> excess sweating     | <input type="checkbox"/> shortness of breath    | <input type="checkbox"/> nighttime urination          |
| <input type="checkbox"/> fatigue             | <input type="checkbox"/> swollen feet or ankles | <input type="checkbox"/> easy bruising or bleeding    |
| <input type="checkbox"/> trouble with vision | <input type="checkbox"/> high blood pressure    | <input type="checkbox"/> hot weather intolerance      |
| <input type="checkbox"/> eye pain or redness | <input type="checkbox"/> jaundice               | <input type="checkbox"/> cold weather intolerance     |
| <input type="checkbox"/> hearing trouble     | <input type="checkbox"/> heartburn              | <input type="checkbox"/> increased thirst             |
| <input type="checkbox"/> nose bleeds         | <input type="checkbox"/> difficulty swallowing  | <input type="checkbox"/> increased urinary volume     |
| <input type="checkbox"/> throat discomfort   | <input type="checkbox"/> abdominal pain         | <input type="checkbox"/> fainting                     |
| <input type="checkbox"/> cough               | <input type="checkbox"/> nausea/vomiting        | <input type="checkbox"/> numbness, pins and needles   |
| <input type="checkbox"/> sputum              | <input type="checkbox"/> black stools           | <input type="checkbox"/> tremor                       |
| <input type="checkbox"/> bloody sputum       | <input type="checkbox"/> rectal bleeding        | <input type="checkbox"/> muscle weakness or paralysis |
| <input type="checkbox"/> wheezing            | <input type="checkbox"/> vomiting blood         | <input type="checkbox"/> nervousness                  |
| <input type="checkbox"/> chest pain          | <input type="checkbox"/> diarrhea               | <input type="checkbox"/> depression                   |
| <input type="checkbox"/> heart "skipping"    | <input type="checkbox"/> backache               |   |

HAVE YOU HAD COMPLICATIONS WITH PREVIOUS ANESTHETICS? YES ( ) NO ( )

ARE YOU TAKING STEROIDS (CORTISONE)? YES ( ) NO ( )

PRESENT MEDICATIONS:

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_