CONFIDENTIAL INFORMATION: This information will not be released except by your authorization. This form is used to obtain your complete medical history.

Name:________________________________ Date:________________

Age:____________ Height:____________________ Weight:______________

MEDICAL QUESTIONNAIRE

PERSONAL HISTORY

Do you have, or have you ever had, any of the following? Please circle your answer.

Thyroid	YES	NO
Tuberculosis	YES	NO
Glaucoma	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Pneumonia	YES	NO
Asthma	YES	NO
Emphysema	YES	NO
Rheumatic Fever	YES	NO
High Blood Pressure	YES	NO
Heart Disease	YES	NO
Phlebitis	YES	NO
Ulcer	YES	NO
Venereal Disease	YES	NO
Jaundice or Hepatitis	YES	NO
Gall Bladder Disease	YES	NO
Colitis	YES	NO
Kidney Disease	YES	NO
Kidney Stones	YES	NO
Epilepsy	YES	NO
Severe Allergic Diseases	YES	NO
Bleeding Disorder	YES	NO
Any other Diseases	YES	NO

MEDICATIONS

Please list all medications you are taking.

______________ Dosage__________
______________ Dosage__________
______________ Dosage__________
______________ Dosage__________
______________ Dosage__________

Please list any drug allergies:

____

Latex Allergy YES NO

SURGERY

Have you had any operations? .... YES NO

If yes, please list:

____
____
____
____
____

HOSPITALIZATIONS

Have you ever been hospitalized for medical illness? .... YES NO

If yes, please list:

____
____
____
____
____

HABITS

Please circle your answer.

Have you been a smoker?	YES	NO
Do you drink alcohol?	YES	NO
Do you drink coffee?	YES	NO
If yes, how many cups per day?____________		
Do you exercise regularly?	YES	NO
If yes, describe briefly:		

____
____
____
____

What is the reason you are here today?________________________________

Due to the large volume of lab work and tests which are obtained daily, we will attempt to contact you with your lab values. However, ultimately you are responsible for calling our office for laboratory results.

____

Signature