

MEDICAL QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

SEX: M F HEIGHT: _____ WEIGHT: _____

Please list any surgical procedures and the year they were performed:

Do you have any medication allergies? Yes No If yes please list the allergies and reactions you have below:

Check if an allergy or reaction to Latex Contrast Dye Adhesive Tape Iodine Dairy Other

To your knowledge, do you now have or have you ever had any of the following:

YES

CARDIOVASCULAR

- Irregular Heartbeat
- Mitral Valve Prolapse
- Heart Murmur
- High Blood Pressure
- Palpitations
- AFIB
- High Cholesterol
- Heart Failure
- Heart Attack

HEMATOLOGIC

- Anemia
- Sickle-Cell Anemia
- History of Bleeding/Bruising
- Blood Transfusion
- Phlebitis/Blood clots

PSYCHOLOGICAL

- Anxiety/Depression/Bipolar
- Panic Disorders
- Post Traumatic Stress
- Alzheimer's/Dementia
- Schizophrenia

GASTROINTESTINAL

- Chronic Heartburn/Acid Reflux
- Diverticulitis
- Crohns Disease
- IBS/Ulcerative Colitis
- GI Bleed/Ulcer

YES

RESPIRATORY

- Recent Cold/Bronchitis
- Asbestosis
- Asthma/Wheezing
- Sleep Apnea/Uses CPAP
- Emphysema
- Chronic cough

NEUROLOGIC

- Tremors/Parkinson's
- STROKE/TIA
- Multiple Sclerosis
- Weakness/Paralysis
- Head Injury
- Neuropathy
- Epilepsy/Seizures
- Migraines
- Vertigo
- Restless Legs

ENDOCRINE

- Thyroid Disorder
- Parathyroid Disorder
- Diabetic
- Adrenal Disorder

YES

UROLOGY

- Kidney Stones
- Enlarged Prostate
- Dialysis
- Bladder Retention
- Stress Incontinence
- Urinary Tract Infections

OTHER

- Cancer
 - HIV/AIDS
 - Shingles
 - Chronic Neck/Back Problems
 - Scoliosis
 - Glaucoma
 - Contacts/Glasses
 - Caps/Crowns
 - Dentures/implants
 - Arthritis
 - Osteoporosis/Osteopenia
 - Gout
 - Hearing Aids/Deafness
- ### DEVELOPMENTAL
- Mental Retardation
 - ADHD
 - Autism
 - Learning Disabilities