

## MEDICAL HISTORY QUESTIONNAIRE

Are you currently under the care of, or have you ever been treated by, a physician for any of the following illnesses ? Diabetes, High blood pressure, Heart or Blood vessel disease, Kidney disease, TB or Lung disease, Ulcer disease, Anemia or Bleeding disorders, Hepatitis, Emotional or Psychiatric disorders, Immune disorders or AIDS, Skin cancer, Malignant melanoma, Other types of cancer or malignancies. Please circle and elaborate below:

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Have you ever been hospitalized or had any surgery? If so, please list the following:

<u>Date (Year)</u>	<u>Type of surgery</u>	<u>Name of Doctor</u>	<u>Hospital</u>

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ Is your weight stable? YES NO

Do you have any **allergies to medications?** (Please circle response)

PENICILLIN OR OTHER ANTIBIOTICS	YES	NO
LOCAL ANESTHESIA	YES	NO
OTHER MEDICATIONS	YES	NO

If yes, please list: \_\_\_\_\_

Do you have any bleeding tendencies? YES NO

Are you presently taking, or have you taken within the past month, any medications?

ASPIRIN (or any aspirin-containing over-the-counter medications)	YES	NO
ORAL CONTRACEPTIVES	YES	NO
BLOOD THINNERS	YES	NO
ANY OTHERS (If yes, please list below)	YES	NO

NAME OF MEDICATION 1. \_\_\_\_\_ 2. \_\_\_\_\_

DOSAGE & FREQUENCY \_\_\_\_\_

Do you smoke cigarettes? YES NO

If yes, how many packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcoholic beverages daily or frequently? YES NO

**Please bring to the doctor's attention any history of controlled substance use for medical or recreational purposes.**