***Medical Questionnaire*** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M /F

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Children: \_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: Name, milligram, and frequency: (include over the counter meds)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_ frequency \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_ frequency \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_ frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_ frequency \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_frequency

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past medical history: Diabetes High Blood Pressure Thyroid Stroke Heart Attack Cancer

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Females***: Date of last: mammogram: \_\_\_\_\_\_\_\_\_\_\_\_ Menstrual cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pap smear: \_\_\_\_\_\_\_\_\_, Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of birth control: \_\_\_\_\_\_\_\_\_\_\_ Surgical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Male:*** Last colonoscopy \_\_\_\_\_\_\_\_\_\_\_ PSA Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History: Cigarettes: yes no pack(s) a day: \_\_\_\_\_\_\_ years \_\_\_\_\_ Quit when: \_\_\_\_\_\_\_

Alcohol: yes no how many per: \_\_\_\_\_ Month \_\_\_\_\_ Quit? When: \_\_\_\_\_\_\_\_\_

History of substance abuse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coffee: yes no cups per day: \_\_\_\_\_\_\_\_ soda/tea \_\_\_\_\_\_\_ Energy drinks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccinations: Shingles yes or no Date: \_\_\_\_\_\_\_\_\_\_ Pneumonia: yes no Date:\_\_\_\_\_\_\_\_\_

Flu yes no Date: \_\_\_\_\_ Tetanus Booster: yes no Date: \_\_\_\_\_\_\_ Hep B yes no Date: \_\_\_\_\_\_

Family Medical History: Circle disease that is associated with the family member listed.

Mother’s Mother: Diabetes / High Blood Pressure / Thyroid / Stroke/ Heart Attack /Cancer/ High Cholesterol

Mothers’ Father: Diabetes / High Blood Pressure / Thyroid / Stroke/ Heart Attack /Cancer/ High Cholesterol

Fathers’ Mother: Diabetes / High Blood Pressure / Thyroid / Stroke/ Heart Attack /Cancer/ High Cholesterol

Fathers’ Father: Diabetes / High Blood Pressure / Thyroid / Stroke/ Heart Attack /Cancer/ High Cholesterol

Brother(s) Diabetes / High Blood Pressure / Thyroid / Stroke/ Heart Attack /Cancer/ High Cholesterol

Sister(s) Diabetes / High Blood Pressure / Thyroid / Stroke/ Heart Attack /Cancer/ High Cholesterol

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_