



Medical History Questionnaire

Today's Date _____

Name _____

Birth Date _____

Do you presently have any problem in these areas? If yes, please explain

Integument (skin)	Yes No	_____
Head	Yes No	_____
Eyes	Yes No	_____
Ears, nose, mouth, throat	Yes No	_____
Neck	Yes No	_____
Bones, joints (arthritis)	Yes No	_____
High Blood pressure	Yes No	_____
Kidney Disease	Yes No	_____
Thyroid Disease	Yes No	_____
Prostate Disease	Yes No	_____
Respiratory (lungs breathing, Asthma, Bronchitis)	Yes No	_____
Cardiovascular (heart/blood vessels)	Yes No	_____
Neurological system (e.g. stroke)	Yes No	_____
Lympharies (lymph nodes, swelling)	Yes No	_____
Hematopoietic (Blood)	Yes No	_____
Allergic and immunologic	Yes No	_____
Infectious (e.g. AIDS, Hepatitis)	Yes No	_____
Psychiatric	Yes No	_____
Diabetes	Yes No	_____
Gastrointestinal (stomach, liver)	Yes No	_____
High Cholesterol	Yes No	_____

Medications you take: name, dosage, how many times a day.
(Include Vitamins, Herbal and over the counter meds) _____

Surgeries and hospitalizations you have had in the past: _____

Major illnesses and/or injuries you have had in the past. _____

Do you have any allergies to medications Yes No _____

Are you allergic to latex? Yes No

Are you allergic to tape? Yes NO

Are you allergic to shellfish, iodine or iodine preparations? Yes No

Any other allergies? _____

Pharmacy: _____