# Medical Questionnaire

**Name**:____________________________________________________________

**Date of Birth**:_______________________________________________________

**Address**:____________________________________________________________

**e-mail**:_______________________________

## Medical Status

1. What is your medical doctor's name?_____________________________________
2. What is your medical doctor's phone number?______________________________
3. Date of Last complete physical examination?_______________________________
4. Are you currently under a physicians care?_________________________________
5. Do you have frequent headaches?________________________________________
6. Do you smoke?_____________________________________________________
7. Do you drink alcohol, if yes how much?__________________________________
8. Do you do recreational drugs?_________________________________________
9. (Women) Any possibility that you are pregnant, if yes, when are you due?________
______________________________________________________________________

## Medications

1. Do you routinely take vitamins, herbal substances or natural products?
2. Are you taking any medications? If Yes List:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

3. (Women) Are you taking birth control medications?

## Adverse Reactions or Allergies

1. Are you sensitive or have adverse reactions to any of the following

| | | | |
|---|---|---|---|
| Latex | Metals | Aspirin | Codeine |
| Penicillin | Sulfa Drugs | Local Anesthetic (freezing) | |
| Nitrous Oxide | Barbituates (sleeping pills) | | |

*Any other medications or substances you have been told you are allergic to, or have had adverse reactions to?______________________________________________________________________

**Medical Conditions**

1. Have you ever been treated for or told you have any of the following:

| | | |
|---|---|---|
| Arthritis Asthma | Blood Disorders (Anemia/Leukemia) | Diabetes |
| Cardiovascular Disease | Cancer ________________________ | Emphysema |
| Epilepsy | Glaucoma | Heart Murmur |
| Hepatitis B | HIV (AIDS) | Hypertension |
| Liver Disease | Renal Disease | Tuberculosis |
| Mental Disability | Thyroid Disorder | |
| Rheumatic Fever | Venerial Disease (STD's) | |

Joint Replacement (type/date of surgery)_________________

*Have you been diagnosed with any other medical conditions, problems or disease not listed above?______________________________________________________________________

*Have you had any Major Operations? List and Give approx. dates:

**Additional Information:**

Is there anything you wish to speak privately to the Dr. with? _________________

Print Name:_________________________________

Signed Name:_________________________________________ Date:____________________