

Patient Medical History Questionnaire



Personal History Circle "Yes" or "No" as applicable. Have you ever had:

Cardiac Pacemaker	Yes	No	Liver Disease	Yes	No
Heart Attack	Yes	No	Kidney Disease	Yes	No
Angina/Chest Pains	Yes	No	Paralysis	Yes	No
Emphysema	Yes	No	Leg Cramps	Yes	No
High Blood Pressure	Yes	No	Headache	Yes	No
Diabetes	Yes	No	Depression	Yes	No
Stroke	Yes	No	Shortness of Breath	Yes	No
Blurred/Double Vision	Yes	No	Arm Pain	Yes	No
Blackouts	Yes	No	Low Blood Pressure	Yes	No
Gout	Yes	No	Indigestion/Ulcers	Yes	No
Nervousness/Anxiety	Yes	No	Tuberculosis	Yes	No
Joint Problems	Yes	No	Asthma	Yes	No
Pain that wakes you up	Yes	No	Hernia	Yes	No
Unexplained Weight Loss	Yes	No	Neuropathy	Yes	No
Cancer	Yes	No	Allergy	Yes	No
Blood Clot	Yes	No	Dizziness	Yes	No
Swelling of Legs/Feet	Yes	No	Numbness/Tingling of		
Chronic/Frequent Cough	Yes	No	Extremities	Yes	No
Seizures	Yes	No	Change in Bowel/Bladder		
Pain not affected by activity or position	Yes	No	Control	Yes	No

For all conditions in which a "Yes" was indicated above, please give dates and details below: _____

Do you have any other medical problems which are not listed here (including any recent surgeries)? _____

List current medications and dosages (include over-the-counter meds & vitamins): _____

Your Height _____ Your Weight _____

Do you consume alcohol? Yes No If "Yes," how many drinks per week/month? _____

Do you smoke? Yes No If "Yes," how many packs per week/month? _____

I certify to the best of my knowledge that the above answers are true and correct.

Patient Signature _____ **Date** _____