

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date: _____

Do you Smoke? No Yes How much/day _____ Chewing tobacco? Yes No

Do you Drink Alcohol? No Yes How much/day _____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES/DISORDERS?

Diabetes: Yes _____ No _____	Thyroid condition: Yes _____ No _____
Take insulin: _____	
Gastro/Intestinal conditions/ulcers: Yes _____ No _____	Sleep Apnea: Yes _____ No _____
Cancer: Yes _____ No _____	Do you use a CPAP? Yes _____ No _____
Tuberculosis: Yes _____ No _____	Jaundice/liver condition: Yes _____ No _____
Organ Transplant: Yes _____ No _____	
Lung/Breathing problems: Yes _____ No _____	Kidney condition Yes _____ No _____
Hepatitis/or history of: Yes _____ No _____	dialysis?: Yes _____ No _____
Bleeding conditions or blood clots: Yes _____ No _____	Immune disorders? Yes _____ No _____
Heart Disease	Neurologic conditions Yes _____ No _____
Congestive Heart Failure (CHF) Yes _____ No _____	
high blood pressure Yes _____ No _____	History of any drug resistant infections?
angina/chest pain: Yes _____ No _____	Yes _____ No _____
high cholesterol: Yes _____ No _____	
MI (heart attack): Yes _____ No _____	

Please list any other medical problems of which you believe we should be aware:

Last Bone Density (DEXA) scan: _____ Female patients: Are you now Pregnant? _____

Please list any surgeries that you have had in the past. Some of the more common ones are listed below that you can circle if it pertains to any you have had.

Gallbladder/cholecystectomy	Hysterectomy
Appendectomy	Cesarean section
Laproscopy (stomach scope)	GI procedures
Cataract (eye procedures)	Wisdom teeth/dental work
Tonsils and Adenoids removed	Orthopedic surgeries: (hand, wrist, knee, ankle, shoulder)

Other surgeries or procedures: _____

Any problems in the past with Anesthesia or any blood relatives with history of anesthesia complications? If yes, please list: _____

We order various tests for patients. Please answer a few screening questions:

Are you claustrophobic? Yes _____ No _____

Do you have any metal in your body? No _____ Yes, please list _____

Do you have a pacemaker, ear implants, brain clips, or cardiac stents? _____

Do you have any known Allergies to Medications?

Please Mark Box if None:

Iodine? Reaction _____ Latex? Reaction _____

Others Please list _____

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS:

Plavix/Clopidogrel dose: _____ How often: _____

Coumadin/Warfarin dose: _____ How often: _____

Aspirin dose: _____ How often: _____

Please list the MD that is monitoring any of the above medications _____

Please state the reason as to why you are taking any of the above medications: _____

Please list your heart doctors name _____

Please list your family/PCP doctor's name _____

Any other MD/provider that would assist us in your care _____

Please list your current medications, including any over the counter medications (herbs/vitamins):

Name: _____ dose: _____ How often: _____

Name: _____ dose: _____ How often: _____

Name: _____ dose: _____ How often: _____

Name: _____ dose: _____ How often: _____

Name: _____ dose: _____ How often: _____

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