

MEDICAL HISTORY QUESTIONNAIRE

 Dr. Hazel **Dr. Hales** **Dr. Merrell** **Dr. Higgs** **Dr. Sampson** **Dr. Perry**
 Eric Lowe PA-C **Brett Turner PA-C** **Joseph Webb PA-C** **Travis Nelson PA-C**

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

Do you have any known Allergies to Medications? Please Mark Box if None:
 Iodine? Reaction _____ Latex? Reaction _____
 Others Please list _____

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 ___ Family Hx ___ | Thyroid condition: Yes ___ No ___ Family Hx ___ |
| Take insulin: _____ | |
| Gastro/Intestinal conditions/ulcers: Yes ___ No ___ Family Hx ___ | Sleep Apnea: Yes ___ No ___ Family Hx ___ |
| Cancer: Yes ___ No ___ Family Hx ___ | CPAP?: Yes ___ No ___ Family Hx ___ |
| Tuberculosis: Yes ___ No ___ Family Hx ___ | Jaundice/liver condition: Yes ___ No ___ Family Hx ___ |
| Organ Transplant: Yes ___ No ___ Family Hx ___ | |
| Lung/Breathing problems: Yes ___ No ___ Family Hx ___ | Kidney condition: Yes ___ No ___ Family Hx ___ |
| Hepatitis/or history of: Yes ___ No ___ Family Hx ___ | dialysis? Yes ___ No ___ Family Hx ___ |
| Bleeding conditions or blood clots: Yes ___ No ___ Family Hx ___ | Immune disorders? Yes ___ No ___ Family Hx ___ |
| Heart Disease | Neurologic conditions Yes ___ No ___ Family Hx ___ |
| High blood pressure Yes ___ No ___ Family Hx ___ | History of any drug resistant infections? Yes ___ No ___ Family Hx ___ |
| Angina/chest pain: Yes ___ No ___ Family Hx ___ | |
| High cholesterol: Yes ___ No ___ Family Hx ___ | Eyeglasses Yes ___ No ___ Family Hx ___ |
| MI (heart attack): Yes ___ No ___ Family Hx ___ | Dentures Yes ___ No ___ Family Hx ___ |
| | Hearing Aides Yes ___ No ___ Family Hx ___ |

If you have marked "yes" to any of the above please explain the condition if needed. Please also list any other medical problems of which you believe we should be aware that may not be listed above:

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.

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)

Surgeries or procedures: _____

OVER ----->

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:

Height _____ Weight _____

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? _____

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: _____

Pharmacy of Choice _____

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: _____

Name: _____ dose: _____ How often: _____

Name: _____ dose: _____ How often: _____

Name: _____ dose: _____ How often: _____

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