

# MEDICAL QUESTIONNAIRE

TODAY'S DATE: \_\_\_\_\_

<b>♦ PATIENT INFORMATION:</b>		
NAME:	DATE OF BIRTH:	
AGE:	SEX:	MARITAL STATUS:
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE: ( ) -	WORK: ( ) -	CELL: ( ) -
EMAIL:	FAX: ( ) -	
<b>♦ PHARMACY NAME:</b>	PHONE : ( ) -	FAX: ( ) -
<b>♦ NEXT OF KIN / PERSON TO CONTACT IN CASE OF EMERGENCY:</b>		
NAME:	RELATIONSHIP:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE: ( ) -	WORK: ( ) -	CELL: ( ) -
<b>♦ REFERRING PHYSICIAN:</b>		
NAME:		
ADDRESS:	CITY/STATE:	ZIP CODE:
PHONE: ( ) -	FAX: ( ) -	OTHER: ( ) -
<b>♦ OTHER PHYSICIANS:</b>		
NAME: (PHYSICIAN 1)		SPECIALTY:
PHONE: ( ) -	FAX: ( ) -	OTHER: ( ) -
NAME: (PHYSICIAN 2)		SPECIALTY:
PHONE: ( ) -	FAX: ( ) -	OTHER: ( ) -
NAME: (PHYSICIAN 3)		SPECIALTY:
PHONE: ( ) -	FAX: ( ) -	OTHER: ( ) -

**PLEASE BRIEFLY STATE YOUR REASON FOR THE VISIT TO OUR OFFICE:**

**MEDICAL HISTORY (CHRONIC ILLNESSES AND INJURIES):**

DATE	ILLNESS	TREATMENT

**SURGICAL HISTORY (OPERATION AND PROCEDURES)**

PLEASE LIST IN CHRONOLOGICAL ORDER, FROM THE OLDEST TO THE MOST RECENT

MONTH & YEAR	TYPE OF SURGERY

**HAVE YOU EVER NEEDED A TRANSFUSION OF BLOOD OR BLOOD PRODUCTS?      YES      NO**

**IF YES, BRIEFLY EXPLAIN WHY:**

**PLEASE EXPLAIN ANY ADVERSE REACTIONS?**

**MEDICATION: LYME**

PATIENT NAME: \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS INCLUDING PRESCRIPTIONS YOU ARE TAKING FOR LYME

MEDICATION	DOSAGE	START DATE	REASON FOR TAKING

**SUPPLEMENTS: LYME**

PATIENT NAME: \_\_\_\_\_

PLEASE LIST ALL SUPPLEMENTS INCLUDING PRESCRIPTIONS, HERBAL AND HOMEOPATHIC, YOU ARE TAKING FOR LYME

SUPPLEMENT	DOSAGE	START DATE	REASON FOR TAKING