

MEDICAL QUESTIONNAIRE

TODAY'S DATE: _____

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

