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?

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