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PATIENT HISTORY QUESTIONNAIRE

PATIENT NAME _____ AGE _____ DOB _____

Any known medication allergies? Y N If yes, lists medication and allergic reaction:
_____

MEDICAL HISTORY: Please check the appropriate answer if you have or have had:

YES	NO		YES	NO	
____	____	Prolonged bleeding when cut	____	____	Shortness of breath/lung problems
____	____	Diabetes	____	____	Fainting or black out spells
____	____	Stomach/Intestinal disorder	____	____	Visual problems
____	____	High blood pressure	____	____	Joint pains
____	____	Heart trouble/disease	____	____	Excessive scarring
____	____	Heart murmur	____	____	Autoimmune disorder
____	____	Irregular pulse	____	____	Hepatitis
____	____	Cancer _____	____	____	Any other significant illness

If other please describe: _____

FAMILY HISTORY: Please indicate P for father's side of the family or M for mother's side:

YES	NO		YES	NO	
____	____	Diabetes	____	____	High blood pressure
____	____	Heart disease	____	____	Liver disease
____	____	Stomach/Intestinal disorders	____	____	Lung disorder
____	____	Bleeding disorders	____	____	Emotional problems
____	____	Bone or joint problems	____	____	Cancer _____

PERSONAL HISTORY:
Do you smoke? Y N If yes, how many cigarettes/packs per day? _____
Do you drink alcohol? Y N If yes, how much and how often:_____

LIST PREVIOUS HOSPITALIZATIONS OR SURGERIES AND DATE:

_____

_____

MEDICATIONS TAKEN REGULARLY (Including aspirin, birth control pills, herbal medications and/or dietary supplements)

Medication Name _____ Dosage/frequency _____

Medication Name _____ Dosage/frequency _____

Medication Name _____ Dosage/frequency _____

Medication Name _____ Dosage/frequency _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? Y N

IF FEMALE: DATE OF YOUR LAST MENSTRUAL PERIOD? _____

HAVE YOU TAKEN ASPIRIN-CONTAINING DRUGS IN THE PAST TWO WEEKS? _____

OFFICE USE ONLY-
HISTORY REVIEWED: DATE_____ INITIALS_____ DATE _____ INITIALS _____