



Medical History Questionnaire

Name _____ Age _____

Date of Birth _____ Height _____ Weight _____

Chief Complaint _____

Date of onset/injury _____

How did this injury occur? _____

Occupation _____

List any allergies to medications, food, or skin allergies (tape, sutures, betadine, latex) _____

List reaction: _____

DO YOU HAVE A LUNG CONDITION? YES _____ NO _____ If yes, please explain _____

DO YOU HAVE A HEART CONDITION? YES _____ NO _____ If yes, please explain _____

Do you take Coumadin? YES _____ NO _____ How much and why? _____

Please circle if you have any of the following conditions and list specific type (if applicable):

- | | | |
|---------------------------------|-------------------------|-----------------------------------|
| Anemia-Type: _____ | Chronic Leg Ulcers | Lyme Disease |
| Aneurysms | Deep Vein Thrombosis | Osteoarthritis |
| Angina | Diabetes-Type 1 (IDDM) | Osteoporosis |
| Artery Conditions | Diabetes-Type 2 (NIDDM) | Peripheral Artery Disease (PAD) |
| Asthma | Elevated Cholesterol | Peripheral Vascular Disease (PVD) |
| Atrial Fibrillation (A-Fib) | Emphysema | Phlebitis |
| Bladder Disease | Gerd | Pulmonary Embolism |
| Blood Disorder | Gout | Rheumatoid Arthritis |
| Cancer-Type: _____ | Heart Attacks | Scoliosis |
| Treatment: _____ Chemo | Hepatitis-Type: _____ | Seizure Disorders |
| _____ Radiation | High Blood Pressure | Sleep Apnea |
| _____ Surgery | Hypothyroidism | Stomach Problems-Type _____ |
| In Remission Yes _____ No _____ | Immune Deficiency | Stroke _____ |
| Cardiac Stents | Kidney Disease | TB _____ |
| | Lung Disease | |

Any other conditions not mentioned above? _____

Family Medical History - List any pertinent family medical history: _____

Do you smoke cigarettes? YES _____ NO _____ How long have you smoked and how much? _____

Do you have a past history of smoking? If so, when did you quit? _____

Do you drink alcohol? YES _____ NO _____ How long have you drank and how much? What type of alcohol? _____

Do you or have you used illicit drugs? YES _____ NO _____ If yes, please explain _____

I, the undersigned, have reviewed the above questions and have answered this information to the best of my knowledge. I believe these answers to be true, correct and complete.

Signature of Patient/Guardian _____ DATE _____