

**Patient History Questionnaire**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

MAY WE SEND YOUR CLINICAL SUMMARY FOR THIS VISIT TO YOUR PRIMARY CARE PHYSICIAN?  YES  NO

**Pharmacy Information for Prescription Refills :** \_\_\_\_\_

**MEDICAL HISTORY: Please check box if you have any of the following medical problems**

- Arthritis  Asthma  Bleeding Problems  Cancer  Cholesterol Problems  ADHD  Reflux  
 C.O.P.D.  Diabetes  Heart Trouble  Hepatitis  High Blood Pressure  HIV/AIDS  Stroke  
 MRSA  Eye Diseases  Thyroid Problems  Obstructive Sleep Apnea  Mental Health Problems  
 Other Medical Problems not listed : \_\_\_\_\_

**Have you or a family member ever experienced a problem with anesthesia ?**

NO  YES - please describe: \_\_\_\_\_

**Allergies: Drug, Latex, Food, Adhesive Tape, Betadine - Iodine, Etc.**

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Family History: Do your parents or siblings have any health problems ?**  No  Yes, please describe below

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Social History: Alcohol Use:**  Never  Rarely  Moderate  Daily/How much? \_\_\_\_\_

**Illegal Drug Use:**  Never Type and Frequency? \_\_\_\_\_

**Tobacco Use:**  Never  Current Smoker / Packs per day ? \_\_\_\_\_

Quit/when? \_\_\_\_\_ How many years did you use tobacco products? \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Current Medications: Include aspirin, vitamins, diet pills, birth control pills, herbs, etc.**

MEDICATION	DOSAGE	MEDICATION	DOSAGE
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____