PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name:_____
Date of Birth_____
Reason for Visit_____
How long have you had this problem?_____

Please list all medications you are currently taking (prescribed and over-the-counter).

NAME OF MEDICATION	DOSAGE	FREQUENCY	INDICATIONS

Are you allergic to any medications? _____Yes _____ No
What?_____
Type of Reaction_____

Please list surgical operations you have had (including childhood surgeries):

PROCEDURE	DATE

Do you smoke? _____Yes _____No If yes, how many packs per day?_____
Have you ever smoked? _____Yes _____No If yes, when did you quit?_____
Do you drink? _____Yes _____No If yes, how much per week?_____

FOR FEMALES ONLY

Number of children_____
Number of miscarriages_____
Number of deliveries_____ □ Vaginal □ C-Section
Last menstrual period_____ □ Heavy □ Light □Clots Number of days____
If you have had a hysterectomy:
When:_____ □ Partial □ Complete
□ Vaginal □ Abdominal
Type of birth control_____
Could you be pregnant now?_____