

# MEDICAL HISTORY QUESTIONNAIRE

\_\_\_\_\_ **Dr. Hazel** \_\_\_\_\_ **Dr. Merrell** \_\_\_\_\_ **Dr. Higgs** \_\_\_\_\_ **Dr. Perry** \_\_\_\_\_ **Dr. Peterson** \_\_\_\_\_ **Dr. Sahota**  
 \_\_\_\_\_ **Eric Lowe PA-C** \_\_\_\_\_ **Brett Turner PA-C** \_\_\_\_\_ **Joseph Webb PA-C**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Do you have any known Allergies to Medications? Please Mark Box if None:   
 Iodine?  Reaction \_\_\_\_\_ Latex?  Reaction \_\_\_\_\_  
 Others  Please list \_\_\_\_\_  
 \_\_\_\_\_

Do you Smoke? No  Yes  How much/day \_\_\_\_\_ Chewing tobacco? No  Yes   
 Do you Drink Alcohol? No  Yes  How much/day \_\_\_\_\_ Dominant Hand? Left  Right

**DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES/DISORDERS?**

Diabetes	Yes ___ No ___	Family Hx ___	Thyroid condition	Yes ___ No ___	Family Hx ___
Take insulin _____					
Gastro/Intestinal conditions/ulcers	Yes ___ No ___	Family Hx ___	Sleep Apnea	Yes ___ No ___	Family Hx ___
Cancer	Yes ___ No ___	Family Hx ___	CPAP?	Yes ___ No ___	Family Hx ___
Tuberculosis	Yes ___ No ___	Family Hx ___	Jaundice/liver condition	Yes ___ No ___	Family Hx ___
Organ Transplant	Yes ___ No ___	Family Hx ___			
Lung/Breathing problems	Yes ___ No ___	Family Hx ___	Kidney condition	Yes ___ No ___	Family Hx ___
Hepatitis/or history of	Yes ___ No ___	Family Hx ___	dialysis?	Yes ___ No ___	Family Hx ___
Bleeding conditions or blood clots	Yes ___ No ___	Family Hx ___	Immune disorders?	Yes ___ No ___	Family Hx ___
Heart Disease			Neurologic conditions	Yes ___ No ___	Family Hx ___
High blood pressure	Yes ___ No ___	Family Hx ___	History of any drug resistant infections?		
Angina/chest pain	Yes ___ No ___	Family Hx ___		Yes ___ No ___	Family Hx ___
High cholesterol	Yes ___ No ___	Family Hx ___	Eyeglasses/Contacts	Yes ___ No ___	Family Hx ___
MI (heart attack)	Yes ___ No ___	Family Hx ___	Dentures	Yes ___ No ___	Family Hx ___
Heart Problems	Yes ___ No ___	Family Hx ___	Hearing Aides	Yes ___ No ___	Family Hx ___

If you have marked "yes" to any of the above please explain the condition if needed. Please also list any other medical problems of which you believe we should be aware that may not be listed above:

\_\_\_\_\_

\_\_\_\_\_

Last Bone Density (DEXA) scan: \_\_\_\_\_ Female patients: Are you now Pregnant? \_\_\_\_\_

Please list any surgeries that you have had in the past. Some of the more common ones are listed below.

Gallbladder/cholecystectomy, Hysterectomy, Appendectomy, Cesarean section, Laparoscopy (stomach scope), GI procedures, Cataract (eye procedures), Wisdom teeth/dental work, Tonsils and Adenoids removed, Orthopedic surgeries: (hand, wrist, knee, ankle)

Surgeries or procedures: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OVER ----->**

Any problems in the past with Anesthesia or any blood relatives with history of anesthesia complications? If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

We order various tests for patients. Please answer a few screening questions:

Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you claustrophobic? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any metal in your body? No \_\_\_\_\_ Yes, please list \_\_\_\_\_

Do you have a pacemaker, ear implants, brain clips, or cardiac stents? \_\_\_\_\_

**ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS:**

Plavix/Clopidogrel  dose: \_\_\_\_\_ How often: \_\_\_\_\_

Coumadin/Warfarin  dose: \_\_\_\_\_ How often: \_\_\_\_\_

Aspirin  dose: \_\_\_\_\_ How often: \_\_\_\_\_

Please list the MD that is monitoring any of the above medications \_\_\_\_\_

Please state the reason as to why you are taking any of the above medications: \_\_\_\_\_  
\_\_\_\_\_

Pharmacy of Choice \_\_\_\_\_

Please list your heart doctors name \_\_\_\_\_

Please list your family/PCP doctor's name \_\_\_\_\_

Any other MD/provider that would assist us in your care \_\_\_\_\_

Please list your current medications, including any over the counter medications (herbs/vitamins):

Name: \_\_\_\_\_ dose: \_\_\_\_\_ How often: \_\_\_\_\_

Name: \_\_\_\_\_ dose: \_\_\_\_\_ How often: \_\_\_\_\_

Name: \_\_\_\_\_ dose: \_\_\_\_\_ How often: \_\_\_\_\_

Name: \_\_\_\_\_ dose: \_\_\_\_\_ How often: \_\_\_\_\_

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