PATIENT MEDICAL QUESTIONNAIRE

Date *m* _____ *d* _____ *y* _____

Patient's name___________________________ Physician's name ______________________________________

Physician's phone (   )_________________ Physician's address_____________________________________

1. Is the patient presently in good health? . . . yes no unsure
2. Is the patient currently under medical care? . . . yes no unsure

   Describe____

3. Is the patient taking any medication? . . . . yes no unsure
4. Has the patient been hospitalized in the last five years? . . yes no unsure

   Reason____

5. Does the patient now have, or has ever had:
   - a) Rheumatic fever or heart murmur . . . yes no unsure
   - b) Heart disease . . . . . . yes no unsure
   - c) High or low blood pressure . . . . yes no unsure
   - d) Chest pains . . . . . . yes no unsure
   - e) Asthma . . . . . . yes no unsure
   - f) Epilepsy or seizures . . . . . yes no unsure
   - g) Hepatitis . . . . . . yes no unsure
   - h) Liver disease . . . . . . yes no unsure
   - i) Tuberculosis or any respiratory disease . . . yes no unsure
   - j) Stomach or kidney problems . . . . yes no unsure
   - k) Bleeding problems . . . . . yes no unsure
   - l) Blood disorders . . . . . yes no unsure
   - m) AIDS, HIV or related syndromes . . . . yes no unsure
   - n) Psychiatric care . . . . . yes no unsure
   - o) Cancer or radiation treatment . . . . yes no unsure
   - p) Allergies to any medication . . . . yes no unsure

     Describe____

6. Is the patient pregnant? . . . . . yes no unsure
7. Any other health concerns?