Medical Questionnaire – (Past Medical History /Review of Systems)

Date:_______________

Patient Name: ____ **Patient D.O.B.** __________________________

Occupation: ____

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily Drinks/wk (Hard alcohol, beer and/or wine) _______	
Use of Tobacco:	Never	Rarely	Previously, but quit, When?_____	Currently Packs/day?______ Years? _____	
Use of Drugs:	Never	Rarely	Previously, but quit, when? ______		
Use of Caffeine	Never	Rarely	Cups per day - ________		

Family Medical History

Father	Age	Diseases	Deceased Y or N	**Cause of Death / Age of Death**
Mother	Age	Diseases	Deceased Y or N	**Cause of Death / Age of Death**
Siblings	Age	Diseases	Deceased Y or N	**Cause of Death / Age of Death**
	Age	Diseases	Deceased Y of N	**Cause of Death / Age of Death**
	Age	Diseases	Deceased Y of N	**Cause of Death / Age of Death**

PLEASE PRINT YOUR CURRENT MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS OR GIVE THE RECEPTIONIST A PRINTED LIST TO COPY

Medications	**Reason for Taking**	**Dosage & Times per Day**	**Prescribing Physician**

Surgeries: (Type/Date): ____

Allergies: ____

Signature of Patient and/or Legal Guardian:____

Date: ____________________________