

# Medical Questionnaire

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Physician: \_\_\_\_\_ Primary MD \_\_\_\_\_

Allergies: \_\_\_\_\_

Designated Driver: \_\_\_\_\_ their cell phone number: \_\_\_\_\_

**Past Medical History: Have you ever had or been treated for any of the following:**

<b>Cardiovascular:</b>	<b>Yes</b>	<b>No</b>
Chest pain or Angina	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Internal Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Open heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias/Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

**Respiratory:**

Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Smoking# packs/day	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

**Neurological:**

Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Back injuries/chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Limited Motion of Neck	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

TMJ(Limited Jaw movement)

**Current Medications:**

See attached List

Drug:	Dosage	Last Dose
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

<b>Hepatic:</b>	<b>Yes</b>	<b>No</b>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Type: _____
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>

<b>Endocrine:</b>	<b>Yes</b>	<b>No</b>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

<b>Gastrointestinal</b>	<b>Yes</b>	<b>No</b>
Reflux disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's/colitis	<input type="checkbox"/>	<input type="checkbox"/>
History of colon polyps	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

**Miscellaneous:**

Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints/Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol intake	<input type="checkbox"/>	<input type="checkbox"/>
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Last Menstrual Period	<input type="checkbox"/>	<input type="checkbox"/> Date _____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: Type	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>
Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

Primary Language Spoken \_\_\_\_\_

**Surgeries: List all surgeries you have ever had**

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

	<b>Yes</b>	<b>No</b>
Aspirin in the last week	<input type="checkbox"/>	<input type="checkbox"/>
Coumadin or Plavix in the last week	<input type="checkbox"/>	<input type="checkbox"/>
Motrin, Aleve, Advil in the last week	<input type="checkbox"/>	<input type="checkbox"/>

**Have you or any family members ever had problems with Anesthesia:** \_\_\_\_\_

**Patients Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Above reviewed and confirmed with patient: Nurses Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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