

Medical Questionnaire

Have you ever had problems with the following?

High Blood Pressure	YES	NO	Explain _____
Recent weight loss/gain	YES	NO	Explain _____
Eyes/ears/nose/throat	YES	NO	Explain _____
Heart disease	YES	NO	Explain _____
Asthma/emphysema/lungs	YES	NO	Explain _____
Stomach/bowel problems	YES	NO	Explain _____
Bladder/Kidney problems	YES	NO	Explain _____
Arthritis	YES	NO	Explain _____
Muscle weakness/bone disease	YES	NO	Explain _____
Skin disease/rash/hives	YES	NO	Explain _____
Seizures/strokes/headaches	YES	NO	Explain _____
Nerve problems/shingles	YES	NO	Explain _____
Diabetes/thyroid problems	YES	NO	Explain _____
Substance/medication overuse	YES	NO	Explain _____
Serious illness/operations	YES	NO	Explain _____
Disease that run in the family	YES	NO	Explain _____
Cancer	YES	NO	Explain _____
Anxiety/depression	YES	NO	Explain _____
Allergies to medications	YES	NO	Explain _____
Are you pregnant?	YES	NO	Explain _____
Are you taking anticoagulants?	YES	NO	Explain _____
Do you drink coffee?	YES	NO	How often? _____
Do you smoke?	YES	NO	Packs per day? _____
Do you consume alcohol?	YES	NO	How often? _____

Please List any medications you take daily. _____

