

Confidential Medical History Questionnaire

(Please fill out completely.)

Name: _____ Age: _____ Date: _____

Height: _____ Weight: _____

Past Medical History:

Do you have any major medical problems? If so please explain briefly.

List any past surgeries: _____

List current medicines: _____

List any allergies: _____

List any allergies to medication: _____

Do you have latex allergy? Yes No

Family History: (yes or no)

Is there a family history of:

Hearing loss?

Cancer?

Diabetes?

Vascular/Heart Disease?

Dizziness?

Acoustic Tumor?

Explain any yes answers: _____

Social History:

Marital Status?

Employment?

Noise Exposure?

Review of Body Systems:

General Health ? ___good ___fair ___poor

Any current active infection? _____ Weight loss? _____ Fever? _____

RESPIRATORY

Do you have: Yes No

Lung or pulmonary disease? ___ ___

Asthma? ___ ___

Bronchitis? ___ ___

Do you smoke? ___ ___

If so, how much do you smoke a day? _____

CARDIOVASCULAR

Do you have: Yes No

Heart disease? ___ ___

An irregular heartbeat? ___ ___

A heart murmur? ___ ___

GASTROINTESTINAL

Do you have:	Yes	No
Stomach/digestive problems? ___	___	___
Ulcers past?___ present?___	___	___
Constipation?	___	___
Diarrhea?	___	___
Blood in your stool?	___	___

GENITOURINARY

Do you have:	Yes	No
Current bladder/kidney infection? ___	___	___
Stinging or burning?	___	___
Frequency of urination?	___	___
A vaginal infection?	___	___
Any chance of pregnancy?	___	___

NEUROLOGICAL / ENDOCRINE

Do you have:	Yes	No
Neurological disease?	___	___
Seizures?	___	___
Endocrine disease?	___	___
Diabetes?	___	___

MUSCULOSKELETAL/SKIN

Do you have:	Yes	No
Joint disease? Where?	___	___
Muscular disease?	___	___
Skin disease?	___	___

Have you been HIV tested? ___ ___ What was the result?_____

If you are in a high risk group for HIV/AIDS, please discuss with your surgeon before surgery.

Please explain all Yes answers: _____

Please describe your current complaint/ problem:

Pharmacy Name: _____ Phone #: _____