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MEDICAL QUESTIONNARIE

PATIENT NAME:_____ DATE OF BIRTH:_____ DATE:_____

Pharmacy: _____ Address: _____ Phone:_____

Briefly state the reason for today's visit? _____

_____

List all illnesses and/or hospitalizations/surgeries you have had during your life: _____

_____

_____

_____

List ALL the medications you are currently taking:_____

_____

Medication Allergies:_____

Who lives at home with you? _____
Do you use an assistive device? If so, what? Ex. Cane or walker _____
Do you drink alcohol? Yes / No How often? _____
Do you smoke? Yes / No How many packs per day _____
Do you drink coffee or caffeinated soda? Yes / No If so how much? _____
Do you use any recreation drugs? Yes /No If so what and how much/often? _____
Do you use health supplements? Yes/ No if so what? _____
Women Only: Are you Pregnant? _____

Have you recently experienced any of the following symptoms? Please circle all that apply.

weight loss	low back pain	vomiting	tremors
weight gain	dizziness	diarrhea	incoordination
fever	headaches	constipation	seizures
night sweats/chills	double vision	weakness	loss of consciousness
palpitations	blurred vision	numbness	joint pain
rash	urinary incontinence	anxiety or depression	swelling
shortness of breath	bowl incontinence	trouble sleeping	
chest pain	slurred speech	snoring	
hearing loss	trouble swallowing	balance problems	
ringing in ears	abdominal pain	frequent falls	
neck pain	nausea	memory loss/confusion	

I certify that the information provided above is complete and true to the best of my knowledge.

_____

Patient/Representative Date