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MEDICAL QUESTIONNAIRE

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

Pharmacy: _____ Pharmacy Address: _____ Pharmacy Phone: _____

Briefly state the reason for today's visit? _____

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

List ALL the medications you are currently taking:

Medication _____	Strength/Dosage _____	Directions _____	Indication _____
Medication _____	Strength/Dosage _____	Directions _____	Indication _____
Medication _____	Strength/Dosage _____	Directions _____	Indication _____
Medication _____	Strength/Dosage _____	Directions _____	Indication _____

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 to TODAYS visit.

- | | | | |
|---------------------|----------------------|-----------------------|-------------------------------|
| 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 | bowel incontinence | trouble sleeping | recent head injury/concussion |
| 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

