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MEDICAL QUESTIONNARIE

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 <u>TODAYS</u> 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