



Medical History Questionnaire

Name: _____

Date: _____

Reason for today's visit?: _____

Are you in any pain?: Yes/No

If yes, how strong? : (none) 1 2 3 4 5 6 7 8 9 10 (worst ever) Where?: _____

How long have you had this issue?: _____

Do you wear pads?: Yes/No How many in a day?: _____ What type?: _____

Any allergies to medications?: _____

Current Medications: _____

Surgeries and Dates: _____

Medical Conditions? (please check before all that apply):

- | | | | |
|----------------------|---------------------------|-----------------------|-----------------|
| Abnormal PAP | COPD | Epilepsy | Hypertension |
| Anemia | Crohn's Disease | Gall Bladder Problems | Hyperthyroidism |
| Anxiety | CVA | Glaucoma | Hypothyroidism |
| Arrhythmias | Degenerative Disc Disease | Gout | IBS |
| Asthma | Depression | Hay Fever | Jaundice |
| Bipolar | Diabetes | Hearing Loss | Kidney Disease |
| CAD | Diverticulosis | Heart Attack | Liver Disease |
| Cancer | Eating Disorder | Hepatitis | Lung Disease |
| CHF | Endometriosis | Hyperlipidemia | Migraines |
| Obesity | Osteoporosis | Pancreatitis | Pneumonia |
| Rheumatoid Arthritis | Seizures | Sickle Cell Anemia | Sleep Apnea |
| Tuberculosis | Ulcerative Colitis | Other: _____ | |

Number of Pregnancies?: _____ Number of Births?: _____

Pharmacy: _____ Phone: _____

Height: _____ Weight: _____