

Medical Questionnaire
(Please print)

Date: _____

Patient Name _____

Specific body part you are being seen for? _____ Left Right

Current Problem and symptoms: _____

If injury or accident, how did it happen? _____

Date of accident/injury? _____

Has this body part been previously injured? No Yes Year? _____

Have you been seen by another Doctor(s) for this problem? No Yes If so, who did you see?

Dr. _____ Dr. _____

Describe treatment: X-Ray ER Medication Hospitalization Surgery
 CAT scan MRI Other _____

Check any illness or conditions that apply to you:

Diabetes Cancer Asthma Venereal Disease High Blood Pressure

Bleeding Tendency Kidney Disease Heart Trouble Rheumatic Fever Low Blood Pressure

Tuberculosis Stroke Seizures Nervous Disorder Positive H.I.V.

Other _____ Year _____

Height _____ Weight _____

Operations:

Drug Allergies

Reactions

Medications – Please list the name and dosage of any medication presently being taken:

Have you had serious injuries, broken bones? If so, please list: _____

