Medical History Questionnaire

Name _____

Date _____ Age _____

Height _____ Weight _____

	Yes	No
Are you allergic to any medication?		
Are you allergic to any anesthetic drug?		
Do you drink alcohol?		
Do you smoke?		
Are you or could you be pregnant now?		
Are you taking or have you recently been taking medication for...		
Blood pressure		
Other heart medication		
Diuretics (water pills)		
Antidepressants		
Tranquilizers, sedatives		
Blood thinners		
Steroids		
Insulin		
Other diabetic medication		
Anti-seizure medication		
Eye drops		
Please List Current Medications:		

Have you had or do you still have...	Yes	No
A Cold?		
Bronchitis, a cough?		
Frequent sinus problems?		
Emphysema?		
Asthma?		
Pneumonia?		
Shortness of breath?		
Tuberculosis?		
Any other lung trouble?		
High or low blood pressure?		
Heart failure?		
Heart murmur?		
Chest pain, angina?		
Heart attack(s)?		
Palpitations, irregular or fast heartbeat?		
Rheumatic fever?		
Anemia?		
Sickle cell illness?		
Easy bruising, excessive bleeding?		
Jaundice, hepatitis, liver trouble?		
Back pain or injury?		
Slipped disk, sciatica?		
Arthritis, other joint pain?		
Convulsions, epilepsy?		
Fainting, blackout spells?		
Stroke?		
Polio, paralysis, meningitis?		
Thyroid trouble?		
Diabetes?		
Low blood sugar?		
Kidney trouble?		
Heart burn?		
Ulcers?		
Hernia?		
Any other illness not mentioned above?		