

## Medical Health Questionnaire

Please print & bring with you

Name:	
Occupation:	
Allergies to Medications:	

### Please mention if you have had any of these:

Addiction to Drugs:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol Use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Animals:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Food:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ankylosing Spondylitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Attempted Suicide:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Pain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blindness:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clots in the Legs or Lungs:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Broken Bones:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chlamydia:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Deafness:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diverticulosis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy(Fits or Seizures):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gastroesophageal Reflux:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Genital Warts:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
German Measles:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gonorrhea:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Failure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heartburn:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemorrhoids:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Herpes Genital:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Herpes Oral:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hiatal Hernia:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV or AIDS:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Stones:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lupus Erythematosus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Measles:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Migraine Headaches:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mumps:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Bowel Disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Other Medical Conditions:</b>		
Polio:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Positive TB/PPD Test:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psoriasis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scarlet Fever:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scleroderma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Schizophrenia:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seborrhea:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sjögren's Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Syphilis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco Use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trichomonas:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Family Medical History</b>		
Cancer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiac Problems:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medications: (Mention medication, dose, and frequency)		
Surgical History: (What kind of surgery, location, and date)		