Patient Questionnaire

Name: ______________________________ Today's Date: ______________________________

DOB: ______________________________

Allergies: List all medications and foods as well as reaction to them

______________________________ ______________________________

______________________________ ______________________________

Medications: List current medications and dosages if possible

______________________________ ______________________________

______________________________ ______________________________

Past Medical History: List all medical conditions

______________________________ ______________________________

______________________________ ______________________________

Past Surgical History: List all prior surgeries

______________________________ ______________________________

______________________________ ______________________________

Family History: Please list medical conditions of blood relatives

______________________________ ______________________________

______________________________ ______________________________

Social History:

Do you smoke cigarettes:_____________ _____________Packs/Day _____________Years

Do you drink alcohol: _____________ _____________Drinks/Day

Do you use illicit drugs: _____________ _____________Type