Medical Questionnaire

Exam No. _____ Today's Date: _____

Name: _____ D.O.B._____ Age: _____ Gender: M / F

How did you sleep last night? Excellent Good Fair Poorly

How many hours did you sleep? _____ How many hours do you normally sleep? _____

Did you eat breakfast? YES / NO Did you eat lunch? YES / NO Did you eat dinner? YES / NO

Are you working with a psychiatrist, psychologist, psychotherapist? YES / NO

Name: _____ Reason: _____

Are you taking any medications today (include over-the-counter medications? YES / NO

Name of medication	dosage	when started

Have you used any illegal drugs in the past few day? YES / NO

Name/type of drug	how much	when used

Have you consumed any alcoholic beverages in the past 24 hours? YES / NO

Name/type of alcoholic beverage	how much	when used

Pain / discomfort? YES / NO

Do you have any heart or breathing problems? YES / NO

Describe: _____

_____

Do you have any general health problems? YES / NO

Describe: _____

_____

Have you been admitted to a hospital as a patient in the past 2 years? YES / NO

Date/reason: _____

_____

Have you had a physical or checkup in the past 2 years? c

Describe: _____

_____

Are you diabetic? YES / NO (over 50 using 50 or more units of insulin daily? YES / NO)

Women only: Are you pregnant? YES / NO

How would you describe you present health (circle)? Excellent Good Fair Poor

Completed by:

_____

Signature date