Name: ______________________ Date: ______________________

Medical History Questionnaire

1. Does the patient have any health problems? ◯Yes ◯No
   If yes, please explain____
2. Is the patient currently seeing a physician for any problems? ◯Yes ◯No
   If yes, please explain____
3. Did the patient have any health issues when younger or at birth? ◯Yes ◯No
   If yes, please explain____
4. Does the patient take any medications? ◯Yes ◯No
   If yes, please list, including dosage____________________________________
5. Has the patient ever had an adverse reaction to food or medicine? ◯Yes ◯No
   If yes, please describe____
6. Has the patient ever been injured or stayed in the hospital overnight? ◯Yes ◯No
   If yes, please explain____
7. Is the patient pregnant or has she been pregnant in the past? ◯Yes ◯No
   Is the patient taking a contraceptive? ◯Yes ◯No
8. Has the patient ever had a blood transfusion? ◯Yes ◯No
9. Has the patient ever had any of the following?
   a. Blood problems such as sickle cell anemia______________ ◯Yes ◯No
   b. Easy bleeding of bruising__________________________ ◯Yes ◯No
   c. Seizures or fainting spells__________________________ ◯Yes ◯No
   d. Frequent headaches_______________________________ ◯Yes ◯No
   e. Heart murmur___________________________________ ◯Yes ◯No
   f. Breathing problems or asthma_______________________ ◯Yes ◯No
   g. Frequent cough or tuberculosis(TB)___________________ ◯Yes ◯No
   h. Hepatitis or liver problems__________________________ ◯Yes ◯No
   i. Stomach or bowel problems__________________________ ◯Yes ◯No
   j. Diabetes (sugar), endocrine or hormone problems________ ◯Yes ◯No
   k. Kidney problems_________________________________ ◯Yes ◯No
   l. Hives or skin rash________________________________ ◯Yes ◯No
   m. AIDS/ HIV Venereal disease________________________ ◯Yes ◯No
   n. Birth defect or disability__________________________ ◯Yes ◯No
10. Does the patient have any behavioral or learning disabilities________ ◯Yes ◯No
11. Who takes care of the patient at home?________________________________
12. Has the patient had a disease, condition, or problem not listed above? ◯Yes ◯No
    If yes, please explain____
13. Name of patient's pediatrician of family physician__________________________
    Address_______________________________Phone__________________
    Date of last physical examination______________________________________

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

______________________________________ ______________

Signature Date