

## MEDICAL QUESTIONNAIRE

Correct answers to the following questions will allow Dr. Hanlon-Rogers to treat you so there will not be an emergency, confidential.

Physicians Name: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_  
Have you had any serious illness or operations? Yes No If yes, please describe: \_\_\_\_\_  
Have you ever had a blood transfusion? Yes No If yes, give approximate date: \_\_\_\_\_  
(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No  
Blood Pressure: \_\_\_\_\_  
Are you currently taking any medications? If so, please list \_\_\_\_\_\*

\* If you have an extensive list of meds, we recommend that you bring them with you on the first visit.

Check if you have had any of the following:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Fainting	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Headaches	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Swelling: feet or ankles
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> HIV	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Cough up blood	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Psychiatric Care	

Do you have any allergies to the following:

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Latex	<input type="checkbox"/> Epinephrine
<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Novocaine	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Sulfas	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Codeine

Other: \_\_\_\_\_

Name of nearest relative: \_\_\_\_\_ Phone number: \_\_\_\_\_