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INITIAL QUESTIONNAIRE

DATE: _____

Please read these sheets carefully and answer all the questions to the best of your ability. They will assist us in better treating you. Thank you for your time and cooperation.

NAME: _____
LAST **FIRST** **MIDDLE INITIAL**

AGE: _____ HEIGHT: _____ WEIGHT: _____

Referring Physician(s): _____

Drug Store Name: _____ Drug Store #: _____

Allergies or adverse reactions to MEDICATIONS (pill or injection): _____

Other Allergies: _____

Reason for your visit today: _____

Medical History (Check all that apply)

- ☐ Cancer
- ☐ Chest Pain / Angina
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Renal Disease
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Blood in Urine
- ☐ Urinary Tract Infection

Please list ***all*** medications (prescriptions and non-prescription) you are currently taking. Please indicate the doctor who prescribed them.

MEDICATION	REASON TAKEN	HOW OFTEN	DOCTOR

Please list all surgeries you have had, approximate date or number of years since you had surgery..

SURGERY	YEAR

FAMILY HISTORY (Check all that apply and circle which family members were affected)

☐ High Blood Pressure	Mother	Father	Sister / Brother	Father's Parents	Mother's Parents	Children
☐ High Blood Sugar	Mother	Father	Sister / Brother	Father's Parents	Mother's Parents	Children
☐ Heart Disease	Mother	Father	Sister / Brother	Father's Parents	Mother's Parents	Children
☐ Kidney Disease	Mother	Father	Sister / Brother	Father's Parents	Mother's Parents	Children
☐ Cancer	Mother	Father	Sister / Brother	Father's Parents	Mother's Parents	Children

(Circle or Circle all that apply)

Do you smoke?: _____ Packs per day Chew Tobacco: _____ Cans / Pouches per day
If YES How long? _____If you quit smoking when? _____
Alcohol: (circle one) Daily Weekly Occasionally What type: _____How much per week? _____
Do you take Aspirin? YES NO Do you have heart murmur? YES NO
Do you take Blood Thinners? YES NO Do you have irregularity of a valve? YES NO
Do you have a Pacemaker? YES NO

ADDITIONAL COMMENTS: _____

SIGNATURE OF PATIENT: _____
Thank you very much for taking the time to complete this form.