Medical Questionnaire

Please complete as much of this form as you can prior to your appointment. Estimate dates as well as you can. Please use a separate piece of paper if you need additional room.

Name: _____ Date of Birth: _____

Current Primary Care Doctor: _____

Allergies to medications: ☐ None

_____

_____

Medical conditions for which you are currently treated

Medical conditions or diagnosis	How long have you been treated for this?

Past surgeries

Procedure	Date

Current Medications (omit this section if you bring a printed list of medications)

Medication	Dose	When did you start this?

Family History - please list the members of you family including parents, siblings, and children.

	Age	Medical conditions
Mother		
Father		