Please print this document,
fill it out in full,
and fax it to us at:

310-696-0724

Medical Questionnaire Date: ___________

Name: ______________________________________ Gender: ☐ Male ☐ Female Age: _______
Last First Middle
Birth-date: _________ Birth Place: __________________ Mother's Birth Name: ________________
Social Security Number: ______ - _____ - _______ Driver's License #: ________________________
Marital Status: ☐ Single ☐ Married ~ Spouse's Name _________________________________
Married how long? ___________ ☐ Divorced ☐ Separated ☐ Widowed
Language Spoken: ____________________ Interpreter Required? ☐ Yes ☐ No
Home Address: ____
City: ________________________________ State: _________ Zip-code: ___________-_________
Phone: ________________________________Fax: ______________________________________

Employer: __________________________________ Occupation: __________________________
Address: _______________________________________ Phone: _______________________
City: _________________ State: _____ Zip-code: _________-_______ Fax: ___________________

Emergency Contact: __________________________ Relationship: ________________________
(Not living in the same household)
Address:____
____
City: ____ State: ________ Zip-code: _________-_____

Phone: _____________________________ Fax: __________________________________

Local Telephone Number: (Relative, Friend or Hotel) _____________________________________

1. Referring Physician: ____
   Specialty: ____
   Address: ____
   ____
   City: _____________________________________ State: ________Zip-code: _________-_____
   Phone: __________________________________ Fax: _______________________________

2. Other Physician: ____
   Specialty: ____
   Address:____
   ____
   City: __________________________________ State: __________Zip-code: __________-____
   Phone: ________________________________ Fax: _________________________________

3. Other Physician: ____
   Specialty: ____
   Address: ____
   ____
   City: ______________________________________State: __________Zip-code: ________-____

Periodic reports may be sent to your physician(s).To whom you would like them sent? [Circle number(s)] 1. 2. 3.

Patient Name:________________________________Date of Birth:______________Date_____________

Height: _________ Weight:__________ SS# __________________ Spouse's Name:________________

Allergies	*Yes*	*No*	*Do Not Know*	*List Allergies*	*Explain Reaction*
Drugs					
Food					
Environmental					

Medical History:

☐ Bleeding	☐ Dizziness/ Fainting	☐ Infectious Disease	☐ Shortness of Breath
☐ Blood Disease	☐ Edema	☐ Kidney Disease	☐ Skin Condition
☐ Bone Disorder	☐ Gastrointestinal	☐ Mental Illness	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Pain	☐ Thyroid Disorder
☐ Chipped/Loose Teeth	☐ Hypertension	☐ Pulmonary Disease	☐ Personal History of Anesthesia problems
☐ Dentures	☐ Implanted Device (Shunt, Pump, pacemaker)	☐ Seizures	☐ Family History of Anesthesia problems
☐ Diabetes	**For Women: Date of Last Menstrual Period (LMP):_________		

Please list and describe any previous Hospitalization and/ or Surgeries:

____

____

Have you or family members had a previous history of anesthesia problems? (Explain)

____

____

Do you: Smoke: ____Yes ____No Amount:____

Consume Alcohol ____Yes ____No Amount:____

Medications

Name of Medication		Dose	Frequency	Last Dose	Comments
1.					
2.					

3.					
4.					
5.					
6.					
7.					
8.					

Present Illness

Please describe in your own words the date of onset of your illness, symptoms & treatment:

____
____
____
____
____
____

PATIENT NAME: ________________

PATIENT NAME: ________________

Please indicate if you have had or currently are experiencing any of the following. If you are not sure, please mark Do Not Know and we will be happy to assist you during your scheduled visit.

GENERAL

	Condition	YES	NO	Do Not Know
1.	Swollen or enlarged (lymph) glands			
2.	Diabetes			
3.	Other tumors or cancer			
4.	Mumps			
5.	Rheumatic fever			
6.	Scarlet fever			
7.	Nervous disorders			
8.	Gallbladder disease			
9.	Venereal disease			
10.	Hepatitis			
11.	Cirrhosis			
12.	Epilepsy			

HEAD, EYES, EARS, NOSE THROAT - (HEENT)

	Condition	YES	NO	Do Not Know
1.	Headaches			
2.	Dizziness or fainting spells			
3.	Eye injuries			
4.	Double vision			
5.	Blurring vision			
6.	Eye pain			
7.	Cataracts			
8.	Glaucoma			
9.	Earaches			
10.	Ringing or buzzing in ear			
11.	Decrease / loss of hearing			
12.	Sensation of spinning			
13.	Sinus trouble			
14.	Nose bleeding			
15.	Sore tongue			

16.	Bleeding gums			
17.	Unusual trouble with teeth			
18.	Skin disease			
19.	Skin tumors / moles removed or burned			
20.	Chronic or frequent infections, colds			

ENDOCRINE

	Condition	YES	NO	Do Not Know
1.	Thyroid trouble or goiter			
2.	Thyroid medication or tests			
3.	Frequent Laryngitis			
4.	Hoarseness or change in voice			

BREAST

	Condition	YES	NO	Do Not Know
1.	Lumps in breast			
2.	Pain in breast			
3.	Nipple discharge			

HEART

	Condition	YES	NO	Do Not Know
1.	Heart Disease			
2.	Bleeding tendency or easy bleeding			
3.	High Blood pressure			
4.	Pain or pressure in chest			
5.	Undue shortness in breath (day or night)			
6.	Ankle Swelling			
7.	Pain in legs while walking			
8.	Fast or irregular heart beating (palpitations)			
9.	Heart murmurs			

PULMONARY

	Condition	YES	NO	Do Not Know
1.	Chronic cough, coughed up blood			
2.	Do you have the date of your last chest x-ray?			
3.	Soaking sweats			

4.	Exposure to TB			
5.	Asthma			

GASTRO INTESTINAL

Condition		YES	NO	Do Not Know
1.	Stomach, liver or intestinal trouble			
2.	Recent gain or loss of weight. (lbs.) Gain____________Loss____________			
3.	Decreased appetite			
4.	Difficulty swallowing			
5.	Nausea or vomiting			
6.	Frequent bowel movements			
7.	Constipation			
8.	Recent change in bowel movements			
9.	Black bowel movements			
10.	Blood in stools			
11.	Jaundice			

GENITOURINARY URINARY

Condition		YES	NO	Do Not Know
1.	Kidney trouble			
2.	Frequent or painful urination			
3.	Kidney stones			
4.	Blood in urine			
5.	Sugar or albumin in urine			
6.	Slow starting of urine stream			
7.	Passing urine at night			

MUSCULOSKELETAL

Condition		YES	NO	Do Not Know
1.	Arthritis or rheumatism			
2.	Back or bone pain			
3.	Clumsiness/awkwardness of hands/feet			
4.	Numbness or tingling of hands or feet			
5.	Muscle pain or weakness			

NEUROLOGIC

	Condition	YES	NO	Do Not Know
1.	Forgetfulness			
2.	Reactions to serum, drug or medicine			
3.	Unusual fatigue			
4.	Excessive worry			
5.	Excessive depression			
6.	Nervous disorders			
7.	Sexual impotence			
8.	Seizures			
9.	Strokes			
10.	Trans Ischemic Attack (TIA)			

1.	Alcohol intake: Yes _____ No _____ Indicate next to each the amount of drinks and Frequency – i.e. Daily, Weekly or Monthly. **1.** Beer **2.** Wine **3.** Whiskey **4.** Other			

2.	Smoking: Cigarettes ___ packs _____			

PATIENT NAME: _______________

Women Only

GYNECOLOGICAL

	Condition	YES	NO	Do Not Know
1.	Vaginal bleeding following intercourse			
2.	Painful menstruation			
3.	Irregular or excessive menstruation			
4.	Vaginal discharge			
5.	Been treated for female disorder			
6.	Have you used an intrauterine device			
7.	Have you gone through menopause			

Please list any past breast problems:

Are you taking hormones:

Have you ever taken birth control pills or hormones? ______________________________

Type: ____________________________ how long? __________________

When stopped? ____

Age of onset of menstruation:
Interval between periods:
Date of last period:

Number of pregnancies: ____
Number of births: ____
Number of abortions: ____

Your age at birth of your first child:

Family history of breast problems: ____
____
____

Date of your Last Menstrual Cycle (LMC): ______________________________________

PATIENT NAME: ____________

Past Surgeries (Operations):
Please list in chronological order

DATE	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

Other Hospitalizations:
Please list in chronological order

DATE	TYPE	HOSPITAL	DOCTOR

Radiation Therapy Treatment:
Please list in chronological order.
We need to know when treatment started and when it was completed.

STARTED?		STOPPED?		Area of Body Treated	Hospital	Doctor
Month	Year	Month	Year			

PATIENT NAME: ____________

List any medications you are now taking, date that you started and the date you discontinued: (including over the counter / non-prescription drugs {i.e. Aspirins, Tylenol, Vitamins, Diet Pills, etc.}.

Pain Pills:

Tranquilizers:

Sleeping Pills:

Other:

Please list any medications to which you have had allergic reaction:

Patient Name: ____________

Family History:

RELATION	AGE	STATE OF HEALTH	IF DECEASED – CAUSE OF DEATH	AGE AT DEATH
Father				
Mother				
Spouse				
Brothers				
Sisters				
Children				

Have any of your blood relatives, husband, wife or children had any of the following?

YES	NO	(CHECK EACH ITEM)	RELATION(S)
		Tuberculosis	
		Diabetes	
		Cancer	
		Leukemia	
		Anemia	
		Bleeding Tendency	
		Heart Disease	
		High Blood Pressure	
		Kidney Disease	
		Asthma, Hay Fever, Other Allergy	
		Chronic Arthritis (Rheumatism)	
		Nervous Or Mental Disorder	
		Goiter	
		Emphysema	
		Any Other Illness	