PATIENT QUESTIONNAIRE MEDICAL HISTORY & REVIEW OF SYSTEMS

Yes No 22. Have you ever had or been treated for RESPIRATORY PROBLEMS?
- Yes No Asthma
- Yes No Wheezing
- Yes No Emphysema
- Yes No Chronic Cough or Shortness of Breath
- Yes No Bronchitis
- Yes No Recent Pneumonia
- Yes No Tuberculosis

Yes No 23. Have you ever had or been treated for KIDNEY PROBLEMS?
- Yes No Kidney Failure (Renal Failure)
- Yes No Dialysis (Date Last Done:________)
- Yes No Kidney Stones

Yes No 24. Have you ever had or been treated for DIGESTIVE TRACT PROBLEMS?
- Yes No Liver Problems
- Yes No Hepatitis
- Yes No Yellow Jaundice
- Yes No Cirrhosis of the Liver
- Yes No Peptic Ulcer or Gastritis
- Yes No Hiatal Hernia or GE Reflux
- Yes No Pancreatitis

Yes No 25. Do you have any SKIN DISORDERS?
- Yes No Open wound(s) or rash

Yes No 26. Have you ever had or been treated for ENDOCRINE or METABOLIC DISEASES?
- Yes No Diabetes
- Yes No Low Blood Sugar
- Yes No Thyroid Disease
- Yes No Porphyra

Yes No 27. Have you ever had a PROBLEM WITH COAGULATION or EASY BRUISING OR BLEEDING?
- Yes No Hemophilia
- Yes No Family history of bleeding problems
- Yes No Sickle Cell Anemia or Trait
- Yes No Other Blood Disorder

Yes No 28. Have you ever had or been treated for NEUROLOGIC PROBLEMS?
- Yes No Stroke Year___________
- Yes No Mini-Stroke or TIA Year ________
- Yes No Seizure, Convulsion, or Epilepsy
- Yes No Paralysis or Spinal Cord Injury
- Yes No Herniated Disk or Spinal Stenosis
- Yes No Frequent Headaches or Migraines
- Yes No Pain in arms or legs
- Yes No Numbness or tingling of arms/legs

Yes No 29. Have you ever had or been treated for MUSCLE, BONE, or JOINT PROBLEMS?
- Yes No Trouble Opening Mouth (TMJ)
- Yes No Back Pain or Sciatica
- Yes No Neck Problems
- Yes No Degenerative (Osteo-) Arthritis
- Yes No Rheumatoid Arthritis
- Yes No Muscle Cramps or Weakness
- Yes No Hoarseness (of your voice)

Yes No 30. If you are a female, IS THERE ANY CHANCE THAT YOU COULD BE PREGNANT NOW?

31. If you a female, WHAT IS THE DATE OF THE LAST DAY OF YOUR LAST NORMAL MENSTRUAL PERIOD?_________________

32. Please describe any medical problems not discussed above:

____

33. PLEASE SIGN AND DATE: The information that I have provided is an accurate and current profile of my medical history and review of systems. I have disclosed all of my medical history known to me.

____   ____________________

Patient or Guardian Signature   Date

M.D.'s Initials:______ Date Reviewed:___________