ANDREW D. SMITH, M.D., INC.
MEDICAL QUESTIONNAIRE

TODAYS DATE:______________

NAME:________________________________ AGE:________ DATE OF BIRTH:_______________

PRIMARY CARE DOCTOR:____

DOCTOR WHO REFERRED YOU:____

OTHER PHYSICIAN(S) CARING FOR YOU:____

IS THIS VISIT DUE TO A WORK RELATED INJURY? ☐ YES ☐ NO DATE OF INJURY_________

ARE YOU PREGNANT? ☐ YES ☐ NO

REASON FOR TODAY'S VISIT:____
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PAST MEDICAL HISTORY:

SURGERIES AND HOSPTIALIZATIONS
List all previous surgeries/hospitalizations, and approximate dates:

1.____________________________________ 3.____________________________________

2.____________________________________ 4.____________________________________

CURRENT MEDICATIONS WITH DOSAGES

1.____________________________________ 3.____________________________________

2.____________________________________ 4.____________________________________

Do you take any "blood thinners? ☐ YES ☐ NO
Do you take medication that has aspirin in it? ☐ YES ☐ NO

ALLERGIES TO DRUGS
YES___________**NO**________________

1.________________________________

2.________________________________

3.________________________________

ENVIRONMENTAL ALLERGIES (FOOD)
YES______________**NO**_____________

1.________________________________

2.________________________________

3.________________________________

USE THIS SPACE TO PROVIDE ADDITIONAL INFORMATION FROM THIS PAGE:

____

____

PATIENT NAME:____DATE:___________________________

HAVE YOU BEEN DIAGNOSED WITH OR TREATED FOR ANY OF THE FOLLOWING DISEASES?

Angina or Heart Attack	Yes___	No___	Glaucoma/Cataracts	Yes___	No___
Anesthesia complications	Yes___	No___	Headaches	Yes___	No___
Asthma	Yes___	No___	High Blood Pressure	Yes___	No___
Bladder disease	Yes___	No___	Immune suppression/HIV	Yes___	No___
Bleeding Problems	Yes___	No___	Irregular Heart Beat	Yes___	No___
Blood Transfusions	Yes___	No___	Liver problems/Hepatitis	Yes___	No___
Congestive Heart Failure	Yes___	No___	Sleep Apnea	Yes___	No___
Cancer	Yes___	No___	Snoring	Yes___	No___
Diabetes Mellitus	Yes___	No___	Stroke	Yes___	No___
Emphysema	Yes___	No___	Thyroid Disease	Yes___	No___
Epilepsy	Yes___	No___	Ulcers or Reflux (GERD)	Yes___	No___

REVIEW OF SYSTEMS - PAST THIRTY DAYS (put a check next to any illnesses, problems or symptoms you have had in the past 30 days).

EYES

____Change in Vision
____Pain
____Blurred or double vision
____Glaucoma

RESPIRATORY

____Cough
____Spitting up blood
____Wheezing

GENITOURINARY

____Flank pain
____Problems with urination
____Abnormal urine color

EAR/NOSE/THROAT/MOUTH

____Hearing Loss
____Trouble Swallowing
____Sore throat
____Sinusitis

HEMATOLOGIC/LYMPHATIC

____Slow to heal after cut
____Bleeding or bruising tendency

CONSTITUTIONAL SYMPTOMS

____Fevers, Chills, or Night sweats
____Recent Weight change
____Skin problems____________________

MUSCULOSKELETAL

____Joint pain/stiffness
____Muscle pain/cramps/weakness
____Back pain

CARDIOVASCULAR

____Chest pain
____Palpitations
____Shortness of breath, walking or lying flat
____Swelling of feet, ankles or hands

GASTROINTESTINAL

____Problems with bowel movements
____Nausea or vomiting
____Rectal bleeding, blood in stool, vomiting blood
____Abdominal pain or hearburn

NEUROLOGIC/PSYCHOLOGIC

____Headaches
____Numbness or tingling sensation
____Fainting or loss of consciousness
____Depression/Nervousness/Insomnia

PATIENT NAME:________________________________ DATE:________________________________

FAMILY HEALTH HISTORY

	FATHER	MOTHER
Alive	____Yes ____No	____Yes ____No
Age or Age at Death	____________	____________
Angina or Heart Attack	____Yes ____No	____Yes ____No
Diabetes Mellitus	____Yes ____No	____Yes ____No
Congestive Heart Failure	____Yes ____No	____Yes ____No
High Blood Pressure	____Yes ____No	____Yes ____No
Adverse Anesthetic Reactions	____Yes ____No	____Yes ____No
Liver Problems/Hepatitis	____Yes ____No	____Yes ____No
Bleeding Disorders	____Yes ____No	____Yes ____No

HABITS

Do you now smoke? (____cigars ____cigarettes) ____Yes ____No

How many years__________Packs per day________

Have you ever smoked? ____Yes ____No

How long ago?________ For how many years?_________

How many packs per day?____________ Month/Year you quit _______________

Have you ever used chew or snuff? ____Yes ____No

Do you drink alcohol? ____Yes ____No

How many drinks per day (average)?_________

When did you last drink?___________________

Have you used illicit drugs (including marijuana, heroin, cocaine, LSD, crack)? ____Yes ____No

If yes, circle which ones.

Do you exercise on a regular basis? ____Yes ____No

Type of exercise___________________How often_______________

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Please use this space to provide additional health information you would like us to know___________

____

____

____

____

The information above is true and correct.

____ ________________________

Patient or Person Completing this form/Relationship Date

Reviewed by M.D. ________________________