

Name: _____ DOB: _____ Date: _____

Medications and Past Medical History Questionnaire

To ensure your health and safety we must have an accurate list of all Medications, dosages and instructions you are currently taking.

Medication Name	Mg's	How often taken	Medication Allergies	
			Name	Reaction
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____

Are you taking any of the following?

Aspirin 81mg__ 325mg__ No / Yes
Blood Thinners No / Yes
Fish Oil / Omega 3 No / Yes
Diet Medication No / Yes

Supplements: _____

Are you taking any Anti-inflammatories / NSAIDS: Aleve / Naprosyn / Naproxyn Advil/Motrin (Ibuprofen) Celebrex
Mobic (Meloxicam) Feldene (Piroxicam) Relafen (Nabumetone) Diclofenac (Voltaren) Other _____

Please **circle any symptoms** you currently have:

- GENERAL** – Do you currently have: fever, or chills
- SKIN** – Do you currently have: rash, new skin lesions, or change in moles
- EYES** – Do you currently have: blurred vision, or change in visual acuity Do you wear eye glasses____ contacts____
- EARS** – Do you currently have: ear pain, or difficulty hearing Do you have hearing aids **Yes / No**
- NOSE** – Do you currently have: nasal congestion, discharge, or bleeding
- MOUTH** – Do you currently have: sore throat, or difficulty swallowing
- NECK** – Do you currently have: pain or swelling
- RESPIRATORY** – Do you currently have: shortness of breath, cough, wheezing
- CARDIOVASCULAR** – Do you currently have: palpitations, chest pain, orthopnea, PND, peripheral edema, syncope or claudication
- GASTROINTESTINAL** – Do you currently have: abdominal pain, melena, or bright red blood,nausea, vomiting, diarrhea, constipation
- GENITOURINARY** – Do you currently have: dysuria, frequency of urination, urgency, or hesitancy
- PSYCHIATRIC** – Do you currently have: depression, anxiety, substance abuse or suicide attempts
- ENDOCRINE** – Do you currently have: heat or cold intolerance, weight loss or gain, increasing thirst
- HEMATO-IMMUNOLOGIC** – Do you currently have: easy bruising, bleeding, oral ulcerations or recurrent infections