# Medical Questionnaire

Date: ______________________________

Name: ______________________________ Height: __________

First day of last period: __________________ or Hysterectomy: __________________

List Surgical History: ______________________________

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______________________________

Occupation: __________________ Level of Education: __________________

**General Stress Level:** Low Medium High

**Exercise Level:** Low Medium High

**Diet:** Regular Vegetarian Gluten Free

**Alchohol Intake:** None Occasional Moderate Heavy

**Caffine Intake:** None Occasional Moderate Heavy

**Nonsmoker** **Smoker** If smoker, how much per day

Illegal Drugs:

**List Family History:** ______________________________

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**Personal Medical History:**

Please answer each question: Check (X) all that apply. Have you ever had?

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|---|---|---|---|---|---|
| ____ Date | ☐ | Anemia | ____ Date | ☐ | Heart Conditions |
| ____ Date | ☐ | Anesthesia Complications | ____ Date | ☐ | Heart Disease |
| ____ Date | ☐ | Anxiety Disorder | ____ Date | ☐ | Hepatitis |
| ____ Date | ☐ | Arthritis | ____ Date | ☐ | High Blood Pressure |
| ____ Date | ☐ | Asthma | ____ Date | ☐ | Infertility |
| ____ Date | ☐ | Birth Defects or Inherited Diseases | ____ Date | ☐ | Kidney Disease |
| ____ Date | ☐ | Breast Cancer | ____ Date | ☐ | Kidney or Bladder Problems |
| ____ Date | ☐ | Cancer | ____ Date | ☐ | Lung Disease |
| ____ Date | ☐ | Depression | ____ Date | ☐ | Ovarian Cancer |
| ____ Date | ☐ | Diabetes | ____ Date | ☐ | Psychiatric Illness |
| ____ Date | ☐ | Endometriosis | ____ Date | ☐ | Thyroid Problems |
| ____ Date | ☐ | GI Problems | ____ Date | ☐ | Varicosities |
| ____ Date | ☐ | Headaches or Migranes | ____ Date | ☐ | High Cholesterol |

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