

CASTLEROCK DIGNOSTIC & RESEARCH PHYSICIANS

Medical Questionnaire

DATE _____

NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____

MARITAL STATUS _____ NUMBER OF CHILDREN _____ OCCUPATION _____

PAST MEDICAL HISTORY (check any of the following which you have had or been treated for.)

High blood pressure _____ Heart disease _____ Diabetes _____ Cancer _____
Liver disease _____ Kidney disease _____ Asthma/Emphysema _____ Stomach trouble _____
Neurologic disease (stroke, etc.) _____ Arthritis _____ Other _____

Surgical Procedures	Year & Where	Hospitalizations	Year and Where
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Regular medication (including dosage and frequency. Include prescriptions, over-the-counter, vitamins, birth control pills, etc.)

Allergies to medications _____

Other Allergies _____

FAMILY HISTORY	RELATIONSHIP	AGE IT OCCURRED
Hypertension	_____	_____
Heart attack, stroke	_____	_____
Diabetes	_____	_____
Cancer	_____	_____
Tuberculosis	_____	_____
Glaucoma	_____	_____
Nervous disorder	_____	_____

SOCIAL HISTORY

Cigarettes: _____ packs per day for _____ years Quit? _____

Alcoholic drinks: _____ drinks per day _____ week _____ Month Quit? _____

Coffee: _____ cups per day; pop/tea: _____ glasses per day

Exercise type: _____ days per week _____

Hobbies: _____