



2211 E. Northern Lights
Anchorage, Alaska 99508

Medical History Questionnaire

Name: _____ Occupation: _____

Allergies to medications: (list the name and what happens when taken) _____

Personal Medical History: (If you have ever had any of the following, put an X next to the diagnosis)

- | | | |
|---|--|--|
| <input type="checkbox"/> Addiction to Drugs | <input type="checkbox"/> Hay Fever | Tobacco Use: |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> No |
| <input type="checkbox"/> Allergies to Animals | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Yes Amt used daily: _____ |
| <input type="checkbox"/> Allergies to Food | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Quit Date Quit: _____ |
| <input type="checkbox"/> Anemia (low blood) | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Chew <input type="checkbox"/> Dip <input type="checkbox"/> Pipe |
| <input type="checkbox"/> Angina (chest pains) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Herpes Genital | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes Oral | Alcohol Use: |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> No |
| <input type="checkbox"/> Attempted Suicide | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> High Cholesterol | *If yes, amt consumed per |
| <input type="checkbox"/> Blind | <input type="checkbox"/> HIV or AIDS | week: _____ |
| <input type="checkbox"/> Blood Clots (in lungs or legs) | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Measles | Family Medical History: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraine Headache | Check all boxes that apply: |
| * if YES what type _____ | <input type="checkbox"/> Mumps | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other Bowel Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Polio | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Positive TB/PPD Test | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cardiac Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Schizophrenia | |
| <input type="checkbox"/> Epilepsy (seizures or fits) | <input type="checkbox"/> Seborrhea | |
| <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Syphilis | |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Trichomonas | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Other Medical Conditions: _____ | |

Medications: Please list medication, dose and how often you take it: _____

Surgical History: Please list surgery type, location and date of surgery: _____