



Medical History Questionnaire

DATE: ____/____/____

Name: _____ Date of Birth: _____

1. Do you have allergy? YES NO

	Allergen	Reaction (Rash, Dyspnea, etc)
Food Allergy		
Environmental Allergy		
Medication Allergy		

2. Are you taking any medication currently? If you are, please list the names of the medications below.

3. Any medical conditions that you have or have had before?(ie: asthma, high blood pressure, high cholesterol, gout, stroke, diabetes, heart problem, infection, cancer, hepatitis, mental disorder)
If Yes, When?

4. Have you had any surgery before? If yes, what kind of surgery and when was it?

5. Does your family member have any medical conditions? (ie: asthma, high blood pressure, high cholesterol, gout, stroke, diabetes, heart problem, infection, cancer, hepatitis, mental disorder)

Father		Siblings	
Mother		Child	
Grandfather	Maternal:	Aunt	Maternal:
	Paternal:		Paternal:
Grandmother	Maternal:	Uncle	Maternal:
	Paternal:		Paternal:

6. Do you smoke? YES NO _____pack/day for _____years
7. Which do you smoke? Cigarette or E-Cigarette
8. Have you smoked before? _____years ago for _____years _____pack/day
9. Do you drink alcohol? YES NO _____glass/day or _____glass/week
10. What kind of alcohol do you drink? Beer liquor wine other