

MEDICAL QUESTIONNAIRE

Today's Date: _____

Patient Name: _____

DOB: _____

How were you referred to SBAAG? _____

Who is your Primary Doctor? _____

What brings you to SBAAG? _____

Personal Information:

Gender: Male Female

Place of Birth: _____

Race: White Black Hispanic Asian Other (Specify): _____

Occupation: _____ Employer Name: _____

Tobacco: Do you currently smoke? Yes No How often? _____

Do you have any History of smoking? Yes No How many years did you smoke? _____

Do you live with people who smoke? Yes No

Current Medication:

Please list ALL medications that you are currently taking (including all that were not prescribed by an MD).

Medication:	Dosage:	How Taken:	Frequency:	Date Started:	Taken For:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Check here if list is continued on another page.

Drug Reactions / Allergies:

Please list all known reactions/allergies to any medication:

Medication:	Type of Reaction/Allergy:	When did this occur:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check here if list is continued on another page.

Immunizations:

1. Have you had a tuberculosis skin test (PPD)? Yes No If Yes, was it negative? Yes No

Date of test? _____

2. Do you have an annual flu vaccine? Yes No

3. Have you had a tetanus shot? Yes No If Yes, Date? _____

4. Have you had a pneumococcal vaccine (Pneumovax)? Yes No If Yes, Date of vaccine? _____

Diagnostic Studies:

Have you had a Chest X-ray or Cat-Scan (CT)? _____ Which Study? X-Ray Cat-Scan (CT) When? _____

Have you had a Sinus X-ray or Cat-Scan (CT)? _____ Which Study? X-Ray Cat-Scan (CT) When? _____

Do you have a preferred **Pharmacy**? Name & Location / Phone Number: _____