SURGCENTER HUDSON, LLC

5700 DARROW ROAD, SUITE 109 • HUDSON OH 44236

Phone: (330) 655-5460 Fax: (330) 655-5461

PATIENT MEDICAL QUESTIONNAIRE

PLEASE FILL OUT THE FOLLOWING COMPLETELY (please print):

PATIENT NAME:_____ DOB:_____/_____/_____ SEX: ❑M ❑F

HEIGHT:_____ WEIGHT: _____ FAMILY DOCTOR'S NAME:_____

Date last seen and reason for visit:_____

Do you use any of the following?: ❑Cane ❑Crutches ❑Walker ❑Wheelchair ❑Hearing Aids ❑Dentures

Do you do any heavy lifting at home or work? No ____ Yes ____

Do you: (Please mark all that apply)

Smoke	No ____ Yes ____	How Much?_____
Drink Alcohol	No ____ Yes ____	How Often?_____
Bruise Easily	No ____ Yes ____	Are you on Blood Thinner? No ____ Yes ____
Bleed Easily	No ____ Yes ____	
Faint Easily	No ____ Yes ____	

Have you ever been told that you have (or have had):

Asthma	No ____ Yes ____	
Arthritis	No ____ Yes ____	
AIDS or HIV	No ____ Yes ____	
Blood Transfusion	No ____ Yes ____	What year(s)_____
Bloody Sputum	No ____ Yes ____	
Diabetes	No ____ Yes ____	
Decreased Appetite	No ____ Yes ____	
Emphysema	No ____ Yes ____	
Heart / Heartbeat Problems	No ____ Yes ____	
Hepatitis	No ____ Yes ____	
High Blood Pressure	No ____ Yes ____	
High Cholesterol	No ____ Yes ____	
Kidney / Urinary Problems	No ____ Yes ____	
Persistent Cough	No ____ Yes ____	
Seizures / Convulsions	No ____ Yes ____	
Stroke	No ____ Yes ____	
Thyroid Problems	No ____ Yes ____	
Tuberculosis	No ____ Yes ____	
Unexplained Night Sweats	No ____ Yes ____	
Unexplained Weight Loss	No ____ Yes ____	

Any other diseases or problems that we may need to know about?_____

_____

Women: Last Menstrual Period:_____

Pregnancy test required for all women of childbearing age (10 - 50)

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PLEASE FILL OUT THE FOLLOWING COMPLETELY (please print):

(Use another sheet of paper if necessary)

Please list all medications, vitamins and herbal pills that you are presently taking:

MEDICATION	STRENGTH	HOW OFTEN

Please list the surgeries that you have had:

SURGERY:	YEAR:
SURGERY:	YEAR:
SURGERY:	YEAR:
SURGERY:	YEAR:
SURGERY:	YEAR:

Do you have any allergies to any medications? ❑ Yes ❑ No

If yes, please list here:

MEDICATION	REACTION

Allergies to? (Mark all that apply) ❑ IV Dye ❑ Iodine ❑ Adhesive Tape ❑ Latex

Does patient have Power of Attorney? ❑ Yes ❑ No

Does patient have a Living Will? ❑ Yes ❑ No