General Medical Questionnaire

1. Name: ____
   (*Last name*) (*First name*) (*Alias/Nickname*)

2. Sex: ☐Male ☐Female
   Pregnant: Y/ N
   Breastfeeding: Y / N
   Planning Pregnancy: Y / N

3. Date of Birth: ____________ *(DD/MM/YY)*

4. Primary Care Physician: ___________________________ PCP Phone #: _________________

5. Who referred you/ How did you hear about us: ______________________________________

6. Occupation: _________________________ 7. Employer: ___________________________

8. Allergies/Intolerance (check all that apply):
☐Topical/Local anesthetics
(Lidocaine, Novocaine, etc.)
☐Adhesive/Tape/Band-Aids
☐Sutures/Stitches
☐Aquaphor/Mupirocin (bactroban)
☐Other (include reaction for each):

History of Anaphylaxis: Y / N

Do you carry an Epi-Pen: Y / N

____

9. Family Medical History:
Father:

Mother:

Siblings:

Children:

10. Current and Past Medical Problems: ____

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Current or Previous Tobacco use: Y / N
Type and Amount used:

Current or Previous Alcohol use: Y / N
Type and Amount used:

11. Previous Surgeries: ____

12. Medications (include dosages if known):
Prescription:

OTC/Supplements: