

MEDICAL QUESTIONNAIRE CHART # \_\_\_\_\_

Robert L. Clement, M.D., F.A.C.S.

Name \_\_\_\_\_ Age \_\_\_\_\_
Weight \_\_\_\_\_ Height \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_
Date of last physical exam \_\_\_\_\_ EKG \_\_\_\_\_
Medical doctor \_\_\_\_\_
Surgeon \_\_\_\_\_

Have you ever had:

Yes No
Surgery requiring anesthesia?
Any complications or ill effects related to anesthetic?
Any Blood relative who had anesthesia complications of any kind?
Chest pain, shortness of breath
Palpations or fluttering of heart?
Pneumonia?
Rheumatic fever or heart disease?
Anemia?
Jaundice or liver disease?
Diabetes (sugar in blood)?
High or low blood pressure?
Asthma or hay fever?
Frequent colds or sore throat?
Blood or plasma transfusions?
Chronic cough?
Fainting spells?

1) Do you have (circle each)
Dentures, capped teeth, bridges
Loose teeth,diseased gums, contact lenses,hearing aide, prosthetic device(s),glasses

2) List current medications:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

3) Are you taking diet pills?

Yes \_\_\_\_\_ No \_\_\_\_\_

4) Allergies: Yes No

Tape \_\_\_\_\_
Any Drug \_\_\_\_\_

Specify: \_\_\_\_\_

\_\_\_\_\_
\_\_\_\_\_

FOR WOMEN

Are you pregnant? \_\_\_\_\_

Last menstrual period: \_\_\_\_\_

Number of term pregnancies \_\_\_\_\_

How did you hear about Dr. Clement? \_\_\_\_\_

Your doctor: \_\_\_\_\_

Your friend: \_\_\_\_\_

Web Site: \_\_\_\_\_ Yellow Pages \_\_\_\_\_

5) Habits (circle each):

Alcohol Never Occasionally Daily
Tobacco Never Occasionally Daily
Number of packs: \_\_\_\_\_

6) List previous surgeries

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

7) Are you under care of a pain management physician? \_\_\_\_\_