

21 Upper Ragsdale Drive, Suite 100 Monterey, California 93940 Phone Number: 831-648-8020 Fax Number: 831-648-8023

Medical Questionnaire

Who should we thank for referring you to our clinic	?:
History of medical conditions: (Please check all that apply) 1. Diabetes 2. Hypertension (High blood pressure) 3. Hypotension (Low blood pressure) 4. Hypercholesterolemia (High cholesterol) 5. Hyperthyroldism 6. Hypothyroidism 7. Coronary Artery Disease 8. Heart Attack 9. Cardiac Arrhythmias 10. Stroke 11.Kidney/ Liver 12. Stomach Ulcer 13. Other Medical Conditions:	Medications you are currently taking: (Please check all that apply) 1. Aspirin 2. Coumadin (Warfarin) 3. Lovenox 4. Plavix 5. Any other blood thinners? 6. Please list all other medications you are currently taking and list reason for taking the medication:
Are you allergic or do you have an allergic react 1. Local Anesthesia (Novocain, etc.)? 2. Antibiotics? 3. Sedatives, Barbiturates? 4. Aspirin or Ibuprofen? 5. Codeine or other pain killers? 6. Latex or Rubber Products? 7. Other allergies or reactions? Ple	tion to the following:
Please list all previous surgeries as well as dates pro	ocedures were performed?
Please provide us with a brief history of what we are	e seeing you for today:
Have you received any treatment for this inju-	ry/illness?: YES / NO
Physical Therapy- How many sessions?	Where was it performed?
Injections? – Name of injection?	How many injections?
Medications?- Name of medication(s)?	
Signature:	Date:
Physician's Signature:	Date: