General Medical Questionnaire

1. Name:				
	(Last name) (Fi	rst name)	(Alias/Nickname)	
2. Sex: □ Male	☐ Female 3. Da Pregnant: Y/ N Breastfeeding: Y / N Planning Pregnancy: Y / I	4. Phone ‡	(MM/DD/YYYY) #:	
6. Address:				
7. Primary Care Physician:			PCP Phone #:	
8. Who referred y	ou/ How did you hear abo	out us:		
9. Occupation:		10. Emp	10. Employer:	
11. Allergies/Intolerance (check all that appl □ Topical/Local anesthetics (Lidocaine, Novocaine, etc.) □ Adhesive/Tape/Band-Aids □ Sutures/Stitches □ Aquaphor/Mupirocin (bactroban) □ Other (include reaction for each):		History of A	y): History of Anaphylaxis: Y / N Do you carry an Epi-Pen: Y / N	
12. Family Medical History: Father:		Mother:	Mother:	
Siblings:		Children:	Children:	
13. Current and F	Past Medical Problems:			
14. Current or Previous Tobacco use: Y / N Type and Amount used:			Current or Previous Alcohol use: Y / N Type and Amount used:	
15. Previous Surg	geries:			
16. Medications (include dosages if known): Prescription:		: OTC/Supp	plements:	