Date:______________________________

Dear Patient:

Please take a few minutes to complete this medical history questionnaire. Read each question and circle the answer. When appropriate, simply fill in the blank.

Thank you.
MARIANNE SCHUELEIN, M.D.

NAME:____ **DATE OF BIRTH:**____________________

I have had the following conditions:

Condition			Condition		
Allergies	Yes	No	HIV Positive	Yes	No
Anemia	Yes	No	Headaches	Yes	No
Asthma	Yes	No	Hearing problems	Yes	No
Back/Neck pain	Yes	No	Heart trouble	Yes	No
Bladder infections	Yes	No	High blood pressure	Yes	No
Bronchitis	Yes	No	Neuralgia/neuritis	Yes	No
Cancer	Yes	No	Nervous breakdown	Yes	No
Depression	Yes	No	Pneumonia	Yes	No
Diabetes	Yes	No	Psychiatric problems	Yes	No
Ear infections	Yes	No	Sinusitis	Yes	No
Epilepsy	Yes	No	Stomach ulcer	Yes	No
Genital herpes	Yes	No	Syphilis	Yes	No
Glaucoma	Yes	No	Tuberculosis	Yes	No

Please describe any other health problems: ____

____

Please list any medications you are taking now, including birth control pills:___________

____

Are you **ALLERGIC** to any medications: Yes No If so please list them:________________

____

Please list any hospitalizations and the reason (other than for pregnancy):_____________

____

Are you pregnant? Yes No Do you smoke cigarettes? Yes No #/day _____

Question		
Have you ever abused illicit or prescription drugs?	Yes	No
Do you think you drink too much alcohol?	Yes	No
Have you ever fainted?	Yes	No
Have you ever had a convulsion?	Yes	No
Is your eyesight getting worse?	Yes	No
Do you ever feel lightheaded?	Yes	No
Have you ever had psychiatric treatment?	Yes	No
Have you ever considered committing suicide?	Yes	No
Have you ever had a blood transfusion?	Yes	No
Are you (or have you been) sexually active?	Yes	No
Men?____ Women?____ Both?____		
Have you traveled abroad?	Yes	No
Are you getting allergy "shots?"	Yes	No

Thank you for taking the time to complete this questionnaire. Please feel free to use additional space to note any facts pertaining to your general health that were not included in the questionnaire.