Dr. Thomas Drost MD, ND, FACS
Medical Questionaire

Name: _____ Today's Date: _____
Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed
Number of Children: _____ Ages and Gender: _____
Race/Ethnicity: _____ Language: ☐ English Other:

_____
Date of Birth: _____ Age: _____ Height:_____ Weight:_____
Drug allergies/reaction:_____
Main Complaint(s):_____
Where is the problem: _____
When did problem start :

_____
Other symptoms that occur at same time:_____
Past Medical and Family History:

Condition	Self	Family	Relationship to you
Alcoholism			
Arthritis			
Asthma			
Blood Disorders			
Cancer and type			
Diabetes			
Depression			
Emphysema			
Glaucoma			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Kidney Stones			
Other Not Listed			

Medications/Supplements	Dosage	Medications/Supplements	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Operations/Hospitalizations	Date
_____	_____
_____	_____
_____	_____

_____ _____

Colonoscopy: ◉ yes ○ no

Date:_____

Are you currently: ○ employed ○ retired ◉ disabled ○ occupation:

_____

Do you use tobacco: ◉ past ○ current ○ never how much: _____ quit:_____

Do you drink water: yes no how much:

_____

Do you drink alcohol: ○ past ○ current ○ never how much: _____

quit:_____

How often do you exercise: ____days/week What type of exercise:

_____

Do you currently experience any of the following? Place an "X" in the box if answer is yes

Fever/Chills		Abdominal Pain		Back Pain	
Headache		Nausea/Vomiting		Neck Pain	
Blurry/Double Vision		Indigestion/Heartburn		Urine Retention	
Eye Pain		Constipation		Urine Leakage	
Seasonal Allergies		Diarrhea		Painful Urination	
Tremors		Chest Pain		Urinary Frequency	
Numbness/Tingling		Varicose Veins		Shortness of Breath	
Dizziness		High Blood Pressure		Wheezing	
Excessive Thirst		Skin Rash		Frequent Cough	
Feel Too Hot/Cold		Persistent Itch		Swollen Glands	
Fatigue		Joint Pain		Clotting Disorder	

For Females Only:

Date of Last Menstrual Cycle: _____ #Pregnancies: _____ #Living Children:

_____

Date of Last Mammogram: _____ Any Abnormals: ◉ yes ○ no Date:

_____