Dr. MacKenzie

PATIENT QUESTIONNAIRE

Patient Information

Name_____

City in which you live_____

Phone number for texts alerts ( )

email_____

Occupation_____

Age_____ Who brought you today_____

Reason for your visit today:

Height: *Weight:*

Past Medical History

☐ Heart disease	☐ Asthma	☐ Crohn's disease/IBD	☐ Anemia/low hemoglobin
☐ Heart attack/Angina	☐ COPD	☐ Kidney disease	☐ Parkinson's disease
☐ Congestive heart failure	☐ Shortness of Breath	☐ Renal dialysis	☐ Seizures
☐ Fast heart rate/AFib	☐ Acid reflux/GERD	☐ Urinary tract infections	☐ Back problems
☐ High blood pressure	☐ Stomach ulcers	☐ Diabetes	☐ Arthritis
☐ Pacemaker	☐ Liver disease	☐ Stroke/TIA	☐ Chronic pain
☐ Previous heart surgery	☐ Hepatitis	☐ Thyroid disease	☐ Chronic diarrhea

Please list any additional medical problems:

Previous Surgeries

Please list all procedures and year performed: *None*

Are you a smoker?	No Yes	___packs/day x ___years
Do you smoke marijuana?	No Yes	___everyday ____occasionally
Do you drink alcohol?	No Yes	___drinks/day x ___years
Have you used drugs?	No Yes	___currently ____in the past type_____
Have you had a blood clot?	No Yes	When?_____
Do you take blood thinners?	No Yes	ASA Plavix Warfarin Apixaban Other_____
Any reactions to anesthetic?	No Yes	
Any issues with healing?	No Yes	
Do you bleed easily?	No Yes	
Do you have cancer?	No Yes	
…a family History of cancer?	No Yes	
Do you have Latex allergy?	No Yes	

Please list any allergies: *None*

Please provide a complete list of your medications to the Nurse Coordinator

Thank you for completing the Medical Questionnaire