



Dr. Suzanne Gazda ❖ Dr. R. Braden Neiman

Medical Questionnaire

Date: _____

Patient's Name: _____

Patients Date of Birth: _____

Reason For Visit: _____

Surgeries	Year	Complication

Hospitalizations	Year	Complication

Have you ever had problems with Anesthesia? YES NO

CT/MRI Studies	Location	Date	Doctor Ordering

Family History – Check if any blood relative has had any of the following. Indicate which relative.

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Osteoporosis	Note: _____ _____ _____ _____ _____ _____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Migraines	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Thyroid Problem	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Meniere's Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High Cholesterol	