Universal Shraddha Foundation

Medical Questionnaire

Personal Information					
Name					
Email					
Address				City	
Phone		Zip		DOB	

Current Medication	

Drug Allergies

Medical History (Check all that applicable to you)			
	Diabetic		COPD
	Hypertension		Kidney Stone
	High Cholesterol		Cancer
	Asthma		Other

Past Hospitalization and Surgeries

Family History: Indicate in the space provided blood relatives who have or had the following.	
Heart Disease:	Stroke:
High Blood Pressure:	Cancer:
Mental Illness:	Diabetes:
Epilepsy/Seizures:	Arthritis:
Kidney Disease:	Depression:
Thyroid Disease:	

Social History							
Smoke? (Y/N)		Drugs? (Y/N)		Alcohol? (Y/N)		Exercise ? (Y/N)	

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Doctor Note

Vitals					
Height		**BP**		**Temp**	
Weight		**Pulse**		**O2sat**	

Note: