

HEALTH QUESTIONNAIRE

PATIENT'S NAME: _____ HEIGHT: _____ WEIGHT: _____ AGE: _____

CURRENT PROBLEM: _____

LATEX ALLERGY? YES ___ NO ___ DATE OF LAST TETANUS: _____

DRUG ALLERGIES: _____

LIST CURRENT MEDICATIONS AND DOSAGE:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

HAVE YOU EVER HAD SURGERY? YES ___ NO ___ LIST PROCEDURE, DATE, TYPE OF ANESTHESIA AND ANY COMPLICATIONS _____

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE?

YES	NO	CHEST PAIN	YES	NO	THYROID DISORDER
YES	NO	IRREGULAR HEART BEAT	YES	NO	SEIZURE PROBLEM
YES	NO	ANKLE SWELLING	YES	NO	STROKE
YES	NO	HEART MURMUR	YES	NO	MUSCLE WEAKNESS
YES	NO	ANGINA/HEART ATTACK	YES	NO	HEPATITIS
YES	NO	HIGH BLOOD PRESSURE	YES	NO	KIDNEY PROBLEM
YES	NO	BRONCHITIS	YES	NO	PROSTATE PROBLEM
YES	NO	TUBERCULOSIS	YES	NO	EASY BRUISING OR BLEEDING
YES	NO	ASTHMA	YES	NO	HIV POSITIVE
YES	NO	ULCER (PEPTIC / GASTRIC)	YES	NO	GOUT
YES	NO	DIABETES	YES	NO	RHEUMATOID ARTHRITIS

PLEASE LIST ANY OTHER HEALTH PROBLEMS: _____

YES	NO	IS THERE A POSSIBILITY THAT YOU MAY BE PREGNANT?	
YES	NO	DO YOU SMOKE CIGARETTES?	PACKS PER DAY?
YES	NO	DO YOU DRINK ALCOHOL?	HOW MUCH?

PERTINENT FAMILY MEDICAL HISTORY: _____

ARE YOU ON A SPECIAL DIET? YES ___ NO ___ IF YES, WHAT TYPE? _____

PATIENT SIGNATURE: _____

DATE: _____