HEALTH QUESTIONNAIRE

PATIENT NAME:_____Age:_____

The following questions regarding your health have been carefully selected as pertinent to your care. Please answer to the best of your ability.

Referring Physician: _____

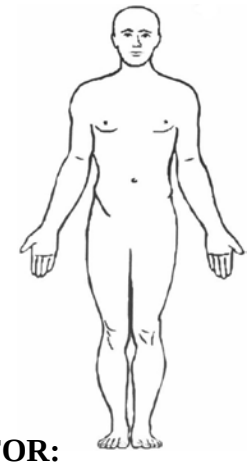
Surgical Problem: _____

Are you in pain: □ Yes □ No

How long have you had this problem?_____

What makes the pain worse? _____

Please mark the site of your pain



HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR:

□ High Blood Pressure □ Tuberculosis □ Coronary Disease □ Rheumatic Fever
□ Diabetes □ Valley Fever □ Hepatitis (A B or C) circle one
□ Emphysema □ Heart Attack □ Asthma

Do you have any reason to believe you may have been exposed to the HIV virus (AIDS) (i.e. blood transfusion, drug use, lifestyle, etc.) □ yes □ no

MEDICATIONS

Are you taking blood thinners?..... □ yes □ no
Have you ever taken medications for your heart?..... □ yes □ no
Have you ever had a general anesthetic?..... □ yes □ no
If yes, any problems? □ yes □ no If yes, explain _____
Are you **ALLERGIC** to any medicines or hospital products, including tape, iodine, latex etc? □ yes □ no
If yes, list allergies_____

LIST ALL MEDICATIONS YOU HAVE TAKEN WITHIN THE PAST TWO WEEKS. Include eye drops, skin ointments, cold tablets, headache medications, birth control pills. Please give dosage.

	Medication	Dosage
1.		
2.		
3.		
4.		
5.		

PAST SURGERIES - Please list all surgeries you have had in the past. If none, check here □

	Surgery	Year	Facility
1.			
2.			
3.			
4.			

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PATIENT NAME:_____

PHYSICAL HABITS

Can you run up a flight of stairs? …… □ yes □ no
Can you walk up a flight of stairs? …… □ yes □ no
How far can you walk? _____
Which sports do you participate in and how often? _____
Any other physical activity, i.e. yard work, housework? □ yes □ no If yes, what? _____
_____

SOCIAL HISTORY

Do you drink alcohol? □ yes □ no If yes, how often? _____
Do you smoke? □ yes □ no If yes, how much? _____

PERSONAL HISTORY

Do you have a pacemaker?: □ yes □ no
What is the most you have ever weighed? _____ Your weight one year ago? _____
When was your last chest xray? _____ Where? _____
When was your last EKG? _____ Where? _____

FAMILY HISTORY

Have any of your family members had any of the following?
□ Diabetes □ Heart Trouble □ Hypertension □ Bleeding Problems
□ Colon Cancer □ Breast Cancer □ Gallstones
□ Other Hereditary or Contagious Diseases If yes, what? _____

FEMALE ONLY

Date of last menustral period _____
Are you pregnant? □ yes □ no If yes, number of months _____
Number of pregnancies _____ Births _____ Other _____

SYSTEMS REVIEW

Please check the following disease or symptoms you have or have had in the past:

□ Eye or Ear Disease	□ Nose or Throat Disease	□ Hoarseness
□ Concussion/Head Injury	□ Stroke	□ Convulsions or Epilepsy
□ Polio or Meningitis	□ Dizziness	□ Headaches
□ Hay Fever	□ Thyroid Disease	□ Pneumonia
□ Emphysema	□ Chronic Cough	□ Shortness of Breath
□ Difficulty Swallowing	□ Spitting Up Blood	□ Night Sweats
□ Heart Disease	□ Angina Pectoris	□ Palpitations
□ Heart Flutter	□ Swelling of Hands/Feet	□ Indigestion
□ Gallbladder Disease	□ Liver Disease	□ Cirrhosis
□ Colitis/Bowel Disease	□ Skin Disease	□ Varicose Veins
□ Anemia	□ Arthritis or Rheumatism	□ Excessive Bleeding
□ Recent Appetite Change	□ Neuritis or Neuralgia	□ Back Problems
□ Hives		

Explanation of above, if necessary _____

PATIENT SIGNATURE: _____ DATE _____