HEALTH QUESTIONAIRE

NAME:	HEIGHT:	WEIGHT:	TODAY'S DATE:

CURRENT MEDICAL HISTORY

HAVE THERE BEEN ANY CHANGES IN YOUR MEDICAL CONDITION WITHIN THE LAST SIX MONTHS? (OR HAVE YOU BEEN TREATED FOR A MEDICAL CONDITION WITHIN THE LAST YEAR? □ YES □ NO

IF YES, WHAT WERE THOSE CONDITIONS? ______________________________.

HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST YEAR? □ YES □ NO

IF YES, FOR WHAT? ______________________________.

HAVE YOU HAD ANY SURGERY IN THE PAST YEAR? □ YES □ NO

IF YES, FOR WHAT? ______________________________.

ALCOHOL: SOCIAL DRINKER □ HEAVY DRINKER □ OCCASIONAL □ NEVER □ (PLEASE CHECK ONE)

TOBACCO (SMOKE OR CHEW): NUMBER OF PACKS PER DAY __________ IF QUIT, HOW LONG? ________________ .

CAFFEINE: □ YES □ NO If yes, how much ______________________________.

RECREATIONAL DRUG USAGE: □ YES □ NO If yes, which/how much ______________________________.

ALLERGIES AND SENSITIVITIES – HAVE YOU EXPERIENCED ANY REACTION FOLLOWING THE ADMINISTRATION OF/ PLEASE LIST REACTION:

NO KNOW DRUG ALLERGIES □

	YES	NO	DON'T KNOW
LOCAL ANESTHETICS	□	□	□
PENICILLIN	□	□	□
KELFLEX	□	□	□
ERYTHROMYCIN	□	□	□
OTHER ANTIBIOTIC	□	□	□
SULFA DRUGS	□	□	□
MORPHINE	□	□	□
CODEINE	□	□	□
DEMEROL	□	□	□
OTHER NARCOTICS (List)	□	□	□
ASPIRIN	□	□	□
EMPIRIN	□	□	□
OTHER PAIN REMEDIES	□	□	□
NSAIDs (Ibuprofen etc., list)	□	□	□
TETANUS ANTITOXIN OR OTHER SERUMS	□	□	□
ADHESIVE TAPE OR SURGICAL TAPE	□	□	□
ANY FOODS (i.e. EGGS, MILK, CHOCOLATE, ETC.)	□	□	□
LATEX	□	□	□

MEDICATIONS: (Please list any medications or supplements that you take REGULARLY, with dose/frequency.)

1. ______________________________.
2. ______________________________.
3. ______________________________.
4. ______________________________.
5. ______________________________.
6. ______________________________.
7. ______________________________.
8. ______________________________.
9. ______________________________.
10. ______________________________.

REVIEW OF SYSTEMS: Have you experienced any of the following in the last few weeks or months?
Please check the complaint and detail below. If you have no complaints in a category, please circle: **NONE**

General:
- ☐ Fever
- ☐ Chill
- ☐ Sweats
- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Weight loss
- ☐ Weight gain

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Loose Stools
- ☐ Blood in Stools
- ☐ Abdominal Pain

Endocrine:
- ☐ Fatigue
- ☐ Hyperactivity
- ☐ Excessive Thirst

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness

Cardiovascular:
- ☐ Chest Pains
- ☐ Fainting
- ☐ Leg Swelling
- ☐ Shortness of Breath
- ☐ Murmur

Skin:
- ☐ Open Sores
- ☐ Boils
- ☐ Wound Breakdown
- ☐ Tender Spots
- ☐ Rash

Heme/Lymphatic:
- ☐ Bruising
- ☐ Bleeding
- ☐ Lymph Node Swelling

Respiratory:
- ☐ Cough
- ☐ Cold
- ☐ Wheezing
- ☐ Painful Breathing
- ☐ Tuberculosis

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Mood Swings

Neurologic:
- ☐ Weakness
- ☐ Numbness
- ☐ Paralysis
- ☐ Loss of Consciousness
- ☐ Headache
- ☐ Tremor
- ☐ Slurred Speech

Allergic/Immunologic:
- ☐ Hives
- ☐ Persistent Infections
- ☐ HIV Exposure
- ☐ Past Blood Transfusion

Eyes/Ears/Nose/Throat:
- ☐ Glasses
- ☐ Contacts
- ☐ Double Vision
- ☐ Impaired Hearing
- ☐ Nosebleeds
- ☐ Sneezing
- ☐ Runny Nose
- ☐ Dentures
- ☐ Dizziness

Genitourinary:
- ☐ Urine Incontinence
- ☐ Urinary Frequency
- ☐ Blood in Urine

Previous Problems:
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Depression
- ☐ Diabetes, Mellitus
- ☐ Esophageal
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Osteoarthritis
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Pneumonia

Pregnancy- Estimated Due Date: ____________________.

Other: ___________________.
_________________________.
_________________________.

Family Medical History: If any relatives have had any please advise which specific relative.

☐ **Patient denies any significant Family History**	☐ **High Cholesterol**
☐ **Anesthesia/Surgical Complications**	☐ **Muscle Dystrophy**
☐ **Asthma/Breathing Complications**	☐ **Osteoarthritis**
☐ **Bleeding Disorders**	☐ **Rheumatoid Arthritis**
☐ **Blood Clot/Phlebitis**	☐ **Strokes/transient Ischemic Attacks (TIA)**
☐ **Cancer**	☐ **Thyroid Disease**
☐ **Connective Tissue Disorder**	
☐ **COPD Chronic Obstruction Pulmonary Disease**	
☐ **Diabetes**	
☐ **Gout**	
☐ **Heart Disease/Heart Attack/Chest Pain**	
☐ **Hepatitis/Liver Disease**	
☐ **High Blood Pressure**	