

Health Questionnaire

Patient's Name _____ Birth date _____

All information you provide will be kept confidential.

1. Has there been any change in your general health in the past year? _____
2. Are you currently under a physician's care? _____ If so, what for? _____

Treating Physician's name? _____ Phone # _____
3. Have you had any serious illness, operations, or hospitalizations? _____
If yes, describe and give approximate dates _____

4. DO YOU HAVE OR HAVE YOU EVER HAD:

Heart (Disease/Surgery/Attack)	Ulcers	Kidney Disease
Congestive Heart Failure	Diabetes	AIDS/HIV positive
Alzheimer's/Parkinson's	Blood Disorders	Depression/Anxiety
Cortisone (Steroid) Medicine	Stroke	Artificial Joints
Thyroid Problems	Emphysema	Hay Fever/Allergies
Chronic sore throat/hoarseness	Tuberculosis	Osteoporosis
High Blood Pressure	Chronic Fatigue	ADHD/ADD
Arthritis/Rheumatism	Liver Disease/Jaundice	Recurrent Infections
Artificial Heart Valve/Pacemaker	Fainting/Dizzy	Epilepsy/Seizures
Chemotherapy/Radiation Therapy	Tumors/Cancer	Asthma
Sleep Apnea/CPAP	Hepatitis A B C	Other _____

Has any disease, drug, or transplant operation depressed your immune system? _____
Please describe _____

LIST ALL CURRENT MEDICATIONS/VITAMINS HERE (attach additional pages if necessary)

WOMEN Are you:

Pregnant-week _____ Breastfeeding _____ Taking Birth Control Pills _____ Taking hormone replacement _____

5. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM TAKING ANY MEDICATION?
Please list _____
6. ARE YOU ALLERGIC TO LATEX? _____
7. Do you use any form of tobacco or vapor? Y N Type _____ How much? _____
How often? _____ For how long? _____
8. Are you, or have you ever been, addicted to drugs or alcohol? _____
9. Do you have any other disease, condition, or problem not listed that you think the doctor should know about? Please list _____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Date

Signature of Patient/Parent/Guardian