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