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, for what? __________________________
   ____
   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:

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

Please describe Yes answers____
____

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

WOMEN Are you: (please circle)

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