HEALTH QUESTIONNAIRE

Patient's Name_____ **Birthdate** _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. All information you provide will be kept confidential.

*****PLEASE ANSWER BY CIRCLING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION**

1. Are you in good health? ……..……..…… Y N
2. Has there been any change in your general health in the past year? ……..……..…… Y N
3. Date of last check up by physician: _____
4. Are you currently under a physician's care? ……..……... Y N
   If so, what for? _____
   Treating Physician's name? _____Phone # _____
5. Have you had any serious illness, operations, or hospitalizations? ……..……..… Y N
   If yes, describe and give approximate dates_____
   _____
   _____
6. DO YOU HAVE OR HAVE YOU EVER HAD:

Heart (Disease/Surgery/Attack)	Y N	Ulcers	Y N	Kidney Disease	Y N
Chest Pain	Y N	Diabetes	Y N	AIDS/HIV positive	Y N
Congenital Heart Disease	Y N	Stroke	Y N	Blood Transfusion	Y N
Heart Murmur	Y N	Glaucoma	Y N	Chronic Cough	Y N
Thyroid Problems	Y N	Emphysema	Y N	Hay Fever/Allergies	Y N
Hepatitis A B C (circle)	Y N	Tuberculosis	Y N	Radiation Therapy	Y N
High/Low Blood Pressure	Y N	Chemotherapy	Y N	Sickle Cell Disease	Y N
Osteoporosis	Y N	Bruise Easily	Y N	Liver Disease/Jaundice	Y N
Artificial Heart Valve/Pacemaker	Y N	Fainting/Dizzy	Y N	Epilepsy/Seizures	Y N
Rheumatic Fever	Y N	Asthma	Y N	Sinus Trouble	Y N
Arthritis/Rheumatism	Y N	Tumors/Cancer	Y N	Artificial Joints	Y N
Cortisone (Steroid) Medicine	Y N	Hemophilia	Y N	Swollen Ankles	Y N
Recurrent Infections	Y N	Anemia	Y N	Nervous/Anxious	Y N

Any disease, drug or transplant operation that has depressed your immune system?……..…… Y N
Please describe _____

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

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_____
_____

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7. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM TAKING ANY MEDICATION?..... Y N
   Please list _____
8. ARE YOU ALLERGIC TO LATEX?……..…… Y N
9. Do you use any form of tobacco? Type _____ Frequency _____For how long? _____... Y N
10. Are you, or have you been, in a drug or alcohol recovery program? ……..……...…….. Y N
11. Do you have any other disease, condition, or problem not listed that you think the doctor should know about? Y N
    Please list _____
12. Do you wish to talk to the doctor privately about anything? …… Y N

WOMEN Are you (please circle)

Pregnant-week_____ Breastfeeding Taking Birth Control Pills Taking hormone replacement

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 Doctor's Initials