Health Questionnaire

ALLERGIES AND SENSITIVITIES

				If yes, specify:
Penicillin or other antibiotics	No	Yes	Don't know	_____
Morphine, Codeine, Demerol or other narcotics	No	Yes	Don't know	_____
Novicain or other anesthetic	No	Yes	Don't know	_____
Aspirin, empirin or other remedies	No	Yes	Don't know	_____
Sulfa drugs	No	Yes	Don't know	_____
Tetanus antitoxin or other serums	No	Yes	Don't know	_____
Adhesive tape	No	Yes	Don't know	_____
Iodine or merthiolate	No	Yes	Don't know	_____
Any other drug or medications	No	Yes	Don't know	_____
Any foods, such as eggs, milk or chocolate	No	Yes	Don't know	_____

OPERATIONS

Have you had any surgeries? If so, in what year(s) and type:

_____

_____

_____

ADVANCE DIRECTIVE

An Advance Directive informs medical professionals what, if any, treatments or procedures will be permitted in the event that you are not able to make the decision yourself.

Do you have an Advance Directive? □Yes □No

DO YOU HAVE OR HAVE YOU HAD:

YES_____ NO_____ Heart disease (including: heart murmur, pacemaker, AICD, catheterization, stents, surgery, mitral valve prolapse)
Specify: _____

YES_____ NO_____ High blood pressure

YES_____ NO_____ Congenital heart defects, artificial, damaged, or malfunctioning heart valves, or history of Rheumatic Fever

YES_____ NO_____ Arrhythmias or irregular heart beats

YES_____ NO_____ Lung disease, chronic cough, abnormal chest x-ray, Shortness of breath (at rest, or with mild exertion)

YES_____ NO_____ Asthma Hospitalization YES_____ NO_____

YES_____ NO_____ Sleep apnea CPAP YES_____ NO_____

YES_____ NO_____ Kidney disease Difficulty voiding YES_____ NO_____ Dialysis YES_ NO____

YES_____ NO_____ Liver disease/Hepatitis/Jaundice. Specify: _____

YES_____ NO_____ Diabetes □Type I □Type II

YES_____ NO_____ Epilepsy/Seizures/Stroke/Neurological problems. Specify: _____

YES_____ NO_____ Anxiety/Depression/Suicidal Thoughts/Bipolar Disorder/Body Dysmorphia. Other:_____

YES_____ NO_____ Autoimmune disorder/Connective tissue disorder/Lupus/Sarcoid/Keloid Scars. Specify:_____

YES_____ NO_____ Thyroid or goiter problems. Specify: _____

YES_____ NO_____ Bleeding or clotting abnormalities. Specify: _____

YES_____ NO_____ Contagious/infectious disease. Specify: _____

YES_____ NO_____ HIV positive, or Exposed to someone who is HIV positive

FAMILY HISTORY

Father: □Alive □Deceased □Unknown Cause of Death:_____
Mother: □Alive □Deceased □Unknown Cause of Death:_____

Place a check mark (√) in the appropriate boxes to identify all illnesses/conditions **which you know have occurred** in your **blood relatives**. Describe the illness or condition.

	Family Members						
Illness/Condition	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	**Describe**
Cancer (describe the type of cancer for each person)							
Heart Disease							
Diabetes							
Stroke							
High Blood Pressure							
High Cholesterol							
Liver Disease							
Alcohol of Drug Abuse							
Anxiety, Depression, or psychiatric illness							
Tuberculosis							
Genetic Disorder							
Convulsion							
Suicide							

Do you have a primary care physician? No Yes

Physician's Name:_____ Phone Number:_____

Patient Name: _____ DOB: _____