

HEALTH QUESTIONNAIRE

PATIENT NAME: _____ Age: _____

The following questions regarding your health have been carefully selected as pertinent to your care. Please answer to the best of your ability.

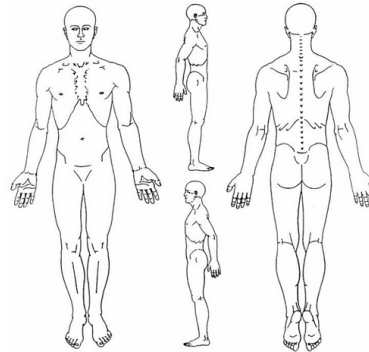
Referring Physician: _____

Surgical Problem: _____

Are you in pain: Yes No

How long have you had this problem? _____

What makes the pain worse? _____



Please mark the site of your pain

HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR:

- | | | | |
|----------------------------------------------|---------------------------------------|----------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Coronary Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Valley Fever | <input type="checkbox"/> Hepatitis (A B or C) circle one | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | |

Do you have any reason to believe you may have been exposed to the HIV virus (AIDS) (i.e. blood transfusion, drug use, lifestyle, etc.) yes no

MEDICATIONS

Have you ever taken medications for your heart?..... yes no

Have you ever had a general anesthetic?..... yes no

If yes, any problems? yes no If yes, explain _____

Are you **ALLERGIC** to any medicines or hospital products, including tape, iodine, latex etc? yes no

If yes, list allergies _____

LIST ALL MEDICATIONS YOU HAVE TAKEN WITHIN THE PAST TWO WEEKS.

Include cold tablets, headache medications, birth control pills. Please give dosage.

Medication	Dosage
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

PAST SURGERIES - Please list all surgeries you have had in the past. If none, check here

Surgery	Year	Facility
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

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PATIENT NAME: _____

PHYSICAL HABITS

Can you run up a flight of stairs? yes no

Can you walk up a flight of stairs? yes no

How far can you walk? _____

Which sports do you participate in and how often? _____

Any other physical activity, i.e. yard work, housework? yes no If yes, what? _____

SOCIAL HISTORY

Do you drink alcohol? yes no If yes, how often? _____

Do you smoke? yes no If yes, how much? _____

PERSONAL HISTORY

Do you have a pacemaker?: _____

What is the most you have ever weighed? _____ Your weight one year ago? _____

When was your last chest x-ray? _____ Where? _____

When was your last EKG? _____ Where? _____

FAMILY HISTORY

Have any of your family members had any of the following?

Diabetes Heart Trouble Hypertension Bleeding Problems

Colon Cancer Breast Cancer Gallstones

Other Hereditary or Contagious Diseases If yes, what? _____

FEMALE ONLY

Date of last menstrual period _____

Are you pregnant? yes no If yes, number of months _____

Number of pregnancies _____ Births _____ Other _____

SYSTEMS REVIEW

Please check the following disease or symptoms you have or have had in the past:

- | | | |
|-------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Eye or Ear Disease | <input type="checkbox"/> Nose or Throat Disease | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Concussion/Head Injury | <input type="checkbox"/> Stroke | <input type="checkbox"/> Convulsions or Epilepsy |
| <input type="checkbox"/> Polio or Meningitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Spitting Up Blood | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Heart Flutter | <input type="checkbox"/> Swelling of Hands/Feet | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Colitis/Bowel Disease | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis or Rheumatism | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Recent Appetite Change | <input type="checkbox"/> Neuritis or Neuralgia | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Hives | | |

Explanation of above, if necessary _____

PATIENT SIGNATURE: _____ DATE _____