



HEALTH QUESTIONNAIRE

NAME _____ **AGE** _____ **HEIGHT** _____ **WEIGHT** _____ **BMI** _____

Have you ever had an **allergic reaction** to any medications? Yes No
 If yes, which medications and what type of reaction? _____

Have you ever had an allergic reaction to X-ray contrast dye? Yes No
 If yes, please describe: _____

Have you ever had a **latex** allergy? Yes No Have you ever had a tape allergy: Yes No

Prescription Medications	Dosage (mg)	Frequency (one, twice per day, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Non-Prescription Medications (Including over-the-counter drugs, supplements, herbs, vitamins, aspirin, etc.)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken cortisone/steroid drugs: Yes No Have you ever had blood products transfused: Yes No
 If yes, when? _____ Where? _____

Please check illnesses that have occurred in any of your **blood** relatives:

<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Nervous disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke

Please check illnesses or conditions that **you** have had or currently have:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> HIV	<input type="checkbox"/> Heart trouble
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Nervous disorder	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Reflux/peptic ulcer disease
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Obesity	<input type="checkbox"/> Elevated cholestero	
<input type="checkbox"/> Other: _____			

SYSTEMIC REVIEW

<p>SKIN:</p> <p>Skin diseases NO YES</p> <p>Hives, eczema, rash NO YES</p> <p>Frequent Infections or boils NO YES</p> <p>Cold sores or fever blisters NO YES</p> <p>Abnormal pigmentation NO YES</p> <p>HEAD, EYES, EARS, NOSE AND THROAT:</p> <p>Dizziness or transient episodes of loss of consciousness NO YES</p> <p>RESPIRATORY:</p> <p>URI (cold) now NO YES</p> <p>Chronic or frequent cough NO YES</p> <p>Asthma or wheezing NO YES</p> <p>Difficulty breathing/shortness of breath NO YES</p>	<p>GENITOURINARY:</p> <p>Frequent Urination NO YES</p> <p>Burning or painful urination NO YES</p> <p>Blood in urine NO YES</p> <p>HEMATOLOGIC:</p> <p>Are you slow to heal after cuts? NO YES</p> <p>Heavy bleeding after tooth extraction/surgery NO YES</p> <p>Abnormal bruising or bleeding NO YES</p> <p>CARDIOVASCULAR:</p> <p>Chest pain or angina NO YES</p> <p>Heart murmur NO YES</p> <p>WOMEN ONLY:</p> <p>Are you pregnant? NO YES</p> <p>Date of last menstrual period _____</p> <p>Most recent mammogram _____</p>	
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Previous operations or hospitalizations (please list procedure and year):

Have you had any serious injuries, broken bones, etc.? Yes No
 If yes, please list: _____

<p>Tobacco use <input type="checkbox"/> Never <input type="checkbox"/> Now <input type="checkbox"/> In the past</p> <p>Alcohol use <input type="checkbox"/> Never <input type="checkbox"/> Now <input type="checkbox"/> In the past</p> <p>Recreational drug use <input type="checkbox"/> Never <input type="checkbox"/> Now <input type="checkbox"/> In the past</p>	<p>How much each day? _____ For how many years? _____</p> <p>When did you quit? _____</p> <p>How much each day? _____ For how many years? _____</p> <p>When did you quit? _____</p> <p>How much each day? _____ For how many years? _____</p> <p>When did you quit? _____</p>
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Patient or Responsible Party Signature: _____ **Date** ____/____/____