

HEALTH QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

1) What is the problem or complaint?

2) How long have you had this problem?

3) What makes it better?

4) What makes it worse?

5) Is there a family history of this?

6) Have you had any surgery? No Yes

**PLEASE LIST ALL:**

7) **FEMALES ONLY:** Are you pregnant? No Yes

8) Please list all medications you are taking, prescription and over the counter:

9) Any medication allergies? No Yes

**PLEASE LIST IF YES:**

10) Tobacco (any form)? No Yes Kind and amount: \_\_\_\_\_

11) Alcohol intake? No Yes Amount: \_\_\_\_\_

12) Past illnesses or hospitalizations (explain if yes):

Heart:	No	Yes	_____
Lung:	No	Yes	_____
Kidney or Bladder:	No	Yes	_____
Neurological/Stroke:	No	Yes	_____
High Blood Pressure:	No	Yes	_____
Diabetes:	No	Yes	_____
Thyroid Disease:	No	Yes	_____
Bleeding Problem:	No	Yes	_____
Glaucoma:	No	Yes	_____
Stomach, Liver, Bowel Problem:	No	Yes	_____
Cancer:	No	Yes	_____
HIV:	No	Yes	_____
Personal or Family History of Anesthesia Problem:	No	Yes	_____

Patient Signature (or Parent): \_\_\_\_\_ WRK: \_\_\_\_\_