Health Questionnaire

Are you in good health? _____ Have you been under the care of a physician during the last 3 years?_____.
Please describe:_____
Date of last visit:_____Name of personal physician:_____
Physician address/Telephone:_____

Please list any other treating physicians;
Name_____Phone:_____Address_____
Name_____Phone:_____Address_____
Person to contact in case of emergency _____Phone: _____
Relationship:_____Alternate Phone:_____

Social History Lifestyle

Do you smoke? _____ How much do you smoke? _____ How long have you smoked? _____
Do you use "smokeless" tobacco? _____ Do you use alcohol? _____
How many drinks per week? _____ Do you use recreational drugs? _____
What type? _____ Last recreational drug used? _____

General Health History

AIDS/HIV	☐ Yes ☐ No	Herpes	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Pacemaker/or Implanted Defibrillator	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Colitis/Intestinal Problems	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Cortizone Treatments	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Cough/persistent	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Epilepsy/seizures	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Fainting/dizziness	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Heart or Bypass Surgery	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Hepatitis A,B,C	☐ Yes ☐ No	Implants or surgical screws	☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No