Health Questionnaire

ALLERGIES AND SENSITIVITIES

Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

				What Drug or Food?
Penicillin or other antibiotics	YES_____	NO_____	DON'T KNOW_____	_____
Morphine, Codeine, Demerol or other narcotics	YES_____	NO_____	DON'T KNOW_____	_____
Novocain or other anesthetic	YES_____	NO_____	DON'T KNOW_____	_____
Aspirin, empirin or other remedies	YES_____	NO_____	DON'T KNOW_____	_____
Sulfa drugs	YES_____	NO_____	DON'T KNOW_____	_____
Tetanus antitoxin or other serums	YES_____	NO_____	DON'T KNOW_____	_____
Adhesive tape	YES_____	NO_____	DON'T KNOW_____	_____
Iodine or merthiolate	YES_____	NO_____	DON'T KNOW_____	_____
Any other drug or medications	YES_____	NO_____	DON'T KNOW_____	_____
Any foods, such as eggs, milk or chocolate	YES_____	NO_____	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:

Heart disease (including: heart murmur, pacemaker, AICD, catheterization, stents, surgery, mitral valve prolapse): YES_____ NO_____ Specify:_____
High blood pressure: YES_____ NO_____
Congenital heart defects, artificial, damaged, or malfunctioning heart valves, or history of Rheumatic Fever: YES_____ NO_____
Arrhythmias or irregular heartbeats: YES_____ NO_____
Lung disease, chronic cough, abnormal chest x-ray, Shortness of breath (at rest, or with mild exertion): YES_____ NO_____
Asthma: YES_____ NO_____
Hospitalization: YES_____ NO_____
Sleep apnea: YES_____ NO_____
CPAP: YES_____ NO_____
Kidney disease: YES_____ NO_____
Difficulty voiding: YES_____ NO_____
Dialysis: YES_____ NO_____
Liver disease/Hepatitis/Jaundice: YES_____ NO_____ Specify:_____

Diabetes: YES_____ NO_____ Type I ___ Type II ___

Epilepsy/Seizures/Stroke/
Neurological problems: YES_____ NO_____ Specify:_____
Autoimmune disorder/Connective tissue disorder/
Lupus/Sarcoid/Keloid Scars: YES_____ NO_____ Specify:_____
Thyroid or goiter problems: YES_____ NO_____ Specify:_____
Bleeding or clotting abnormalities: YES_____ NO_____ Specify:_____
Contagious/infectious disease: YES_____ NO_____ Specify:_____
Are you HIV positive, or have been exposed
to someone who is HIV positive? YES_____ NO_____

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 *(list the type of cancer for each person)*							
Heart Disease							
Diabetes							
Stroke							
High Blood Pressure							
High Cholesterol							
Liver Disease							
Alcohol or 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:_____