# *HEALTH QUESTIONNAIRE*

**Please fill out this form in its entirety. If the question/subject does not apply, please write "N/A" for "Not Applicable". Thank you.**

**Name: _____Date:_____**

**MEDICAL CONDITIONS:**

| TYPE OF CONDITION | ACTIVE OR INACTIVE | DURATION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PAST SURGERIES (INCLUDING COSMETIC SURGERY):**

| DATE | SPECIFIC TYPE OF SURGERY | RIGHT OR LEFT SIDE? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**CURRENT MEDICATIONS:**

| NAME OF MEDICATION | DOSE AND FREQUENCY TAKEN | LENGTH OF TIME USED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**MEDICATION ALLERGIES OR SENSITIVITIES**

| MEDICATION | TYPE OF REACTION |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Do you have a contact allergy to Latex or Metal? _____**

**PLACE A CHECK MARK NEXT TO WHAT YOU HAVE PROBLEMS WITH:**

| | | | |
|---|---|---|---|
| **[ ] General Health** | **[ ] Circulation** | **[ ] Gout** | **[ ] Neurological Disorders** |
| **[ ] Eyes** | **[ ] Lungs** | **[ ] Cancer** | **[ ] Emotional or Psychological Disorders** |
| **[ ] Ears/Nose/Throat** | **[ ] Ulcer/Bowel/Liver** | **[ ] Diabetes** | **[ ] Kidney/Urinary Tract** |
| **[ ] Heart** | **[ ] Reproductive** | **[ ] Thyroid** | **[ ] Long/Short term Infections** |
| **[ ] Hypertension** | **[ ] Stroke / Seizures** | **[ ] Skin Conditions** | **[ ] Rheumatoid Arthritis** |

**History of Orthopaedic Problems? _____**
(Please list)

**PLEASE COMPLETE OTHER SIDE OF PAGE**

# *HEALTH QUESTIONNAIRE PAGE 2*

**WEIGHT: _____lbs** **HEIGHT: _____ft_____in** **HAND DOMINANCE: RIGHT OR LEFT**
(Please Circle One)

**IMMUNIZATIONS**
**[ ] Tetanus_____ [ ] Hepatitis B_____**
**(Date) (Date)**

**1. Have you been treated for a blood clot in your legs? _____ 2. Blood clot in your lungs?_____**

**3. Personal or Family history of a bleeding Disorder? _____ 4. Problems with anesthesia?_____**

**5. Personal history of bruising easily? _____ 6. Bleeding excessively after being cut or after surgery?_____**

**7. Anyone in your family ever pass away during or after a surgery? _____**

**FAMILY MEDICAL HISTORY**

| Relative | Living or Deceased | Health Problems (Please be Specific) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**SOCIAL HISTORY**
**Primary Recreational Activity: _____**

**Nutrition:**
**Do you eat: regularly, skip meals, frequent snacks, or binge? (Circle any that apply)**

**Do you have a: balanced diet, poor diet, special diet, use vitamins or nutrient supplements? (Circle any that apply)**

**Are you concerned with your weight? _____Are you taking any over the counter weight loss aids? _____**

**Do you have a high, normal, or low stress level? _____**

**Do you Smoke? [ ] Yes[ ] No Cigarettes, Cigars, Pipe, Marijuana** (Please Circle What Type)
**How many per day? _____For how long? _____**
**Quit? _____ When? _____**
**Alcohol Use? [ ] Yes [ ] No Beer, Wine or Mixed Drinks** (Please Circle What Type)
**How often? _____**

**FOR CHILDREN UNDER 12 YEARS ONLY**
**Birth History:**
- **[ ] Normal Full Term**
- **[ ] Premature**
- **[ ] Breech**
- **[ ] First Born**

**FOR FEMALES OVER 12 YEARS ONLY**
**Pregnant? _____Number of months: _____**
**Menopausal? _____At what age? _____**
**Age when menstration started? _____**
**Number of Pregnancies: _____**
**Number of living children: _____**
**Age range of Children:**
**Eldest: _____Youngest:_____**