

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:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> General Health | <input type="checkbox"/> Circulation | <input type="checkbox"/> Gout | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Lungs | <input type="checkbox"/> Cancer | <input type="checkbox"/> Emotional or Psychological Disorders |
| <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> Ulcer/Bowel/Liver | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Urinary Tract |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Reproductive | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Long/Short term Infections |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke / Seizures | <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> 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 _____ (Date) [] Hepatitis B _____ (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)

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: _____