HEALTH QUESTIONNAIRE
(IMPORTANT, Please Answer Carefully)

PATIENT'S NAME: _____ Date: _____

AGE: _____ SEX: _____ HEIGHT: _____ ft. _____in. WEIGHT: _____

MEDICAL ALLERGIES: _____

Please list all medications you are currently taking. Please include vitamins, hormones, birth control, and aspirin products.

_____

Do you have any condition which requires you to take antibiotics prior to a procedure: YES or NO
If so, what condition? _____ Antibiotic you usually take? _____

Do you suffer from any of the following?	**YES**	**NO**	**Have you ever had?**	**YES**	**NO**
Bleeding Disorder			A Heart Attack		
Anemia			Any Major Medical Illness		
Diabetes			Hepatitis or Hepatitis Exposure		
Heart Trouble			Any Cortisone Treatment		
Irregular heart beats			Psychiatric Treatment		
High blood pressure			Do you have a family history of:		
Chest pain (angina)			Heart trouble		
Abnormal EKG			Sudden Infant Death(s)		
Rheumatic heart disease			Trouble with anesthetics		
Lungs			Drink alcoholic beverages?		
Shortness of breath			If yes, how much per week?		
Asthma					
Bronchitis			Smoke?		
Emphysema			If yes, how much per day?		
Kidney Trouble					
Eye problems			Use illicit drugs?		
Liver			If yes, please specify.		
Cirrhosis					
Seizures			Exercise regularly?		
Cancer					
AIDS (exposure)			Sleep apnea?		
Are you pregnant at this time?					

List any surgeries you have had:

SURGERY/REASON	**YEAR**	**HOSPITAL**	**PHYSICIAN**

Have you been seriously ill in the past year? _____ If yes, please explain: _____

Patient's Signature