

Health Information as of _____ (today's date).

| | |
|----------------|---------|
| Patient Name: | |
| Date of Birth: | Age: |
| Height: | Weight: |

Please write "YES" in the space provided if you currently or ever had any of the following:

| | |
|--|--|
| Heart Trouble | Glaucoma or Eye problems |
| Heart Attack | Visual Disturbances |
| Heart Pain | Error in Refraction |
| Palpitation or Irregular Pulse | Other Eye problems |
| Extra Heart Beats | Hepatitis |
| Stroke | Yellow Jaundice |
| Hypertension | Gallstones or Gallbladder Trouble |
| Blood Pressure Abnormalities | Cirrhosis of the Liver |
| Abnormal EKG | Alcoholism or Drug Dependency |
| Rheumatic Fever | Esophageal Varices |
| Dropsy or Heart Failure | Frequent Indigestion |
| Digitalis Treatment | Ulcers |
| Shortness of Breath | Gastritis |
| Chest Pain | Colitis |
| Asthma | Problem Constipation |
| Bronchitis | Vomiting Blood |
| Pneumonia | Tarry or Bloody Bowel Movements |
| Tuberculosis | Hemorrhoids |
| Smokers Cough | Goiter or Thyroid Disorders |
| Emphysema | Diabetes |
| Coughing or Spitting of Blood | Skin Disorders |
| Hay Fever | Arthritis |
| Major Allergies | Fracture of Neck or Spine |
| Palsy or Paralysis | Bleeding Tendency or Disorder |
| Nervous Breakdown | Airway Obstruction (Nasal) |
| Nervous Disorder | Breast Cysts, Tumors, Abscesses |
| Psychiatric Hospitalization or Care | Nipple Discharge (Apart from Normal Lactation) |
| Drug Habit | Kidney Disorder |
| Self Destructive Tendencies | Blood Transfusion |
| Thyroid Problems | Seizures, Convulsions, or fainting spells |
| Kidney or Renal Disease | Black Outs |
| Insomnia | Family Members with Bleeding Problems |
| Heart Murmur | Family Members with Anesthesia Problems |
| Positive Blood Test for HIV, AIDS, Hepatitis | Missed or irregular last menstrual period |

Health Questionnaire

1. **Please list all present medications**, including birth control pills, hormones, vitamins, herbal medication, diuretics, weight loss drugs, and over-the-counter medications:

2. Do you have an **Allergic Reaction** to any medication? If yes, please provide details below

3. Have you ever had any difficulties with any medications, drugs, or gases used for **Anesthesia**?

4. How often do you have cocktails or consume regular amounts of **Alcoholic** beverages?

5. Do you **Smoke**? How much and for how long?

6. Have you ever been **Pregnant**?

7. Who is your **Primary Care Doctor**?

8. Please list all **Doctors** currently caring for you:

9. Have you ever been under **Psychiatric Care**? And why?

10. Please list all **Hospitals** and **Surgeries** you've previously had:

11. Anything else the Doctor **should** know?

By Signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature:

_____ Date: _____