HEALTH QUENTIONNAIRE | Blood Pressure _______________

Any changes in your general health this past year? Y_____ N ______

Describe:

HAVE YOU EVER HAD OR NOW HAVE ANY OF THE FOLLOWING:

	Yes	No	Don't know		Yes	No	Don't know		Yes	No	Don't know
Epilepsy or Seizures				Hemophilia				Ulcers			
Fainting or Dizziness				Bruise/ Bleed easily				Kidney problems			
Nervousness/Anxiety				Heart problems/ Angina				Venereal disease/STD			
Stroke				Hypertension				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold sores (herpes)				Heart murmur				HIV/AIDS			
Persistent cough				Mitral valve prolapse				Arthritis			
Emphysema				Congenital heart lesions				Painful joints (incl. jaw)			
Tuberculosis/PPD+				Heart surgery				Prosthetic joint(s)			
Asthma				Prosthetic heart valve				Hives			
Sinus problems				Pacemakers				Steroid medication(s)			
Anemia				Blood transfusion				Drug addiction			
Sickle cell disease				Liver disease				Alcoholism			
Osteoporosis				Yellow jaundice				Unexplained weight chg.			
				Hepatitis-type:				Cancer/radiation			

	Yes	No	Don't know	
Have you ever been told that you should not donate blood?				
Have you ever been told that you need antibiotics before dental treatment?				
Females: Are you taking birth control pills?				
Are you or might you be pregnant?				Estimated delivery?
Are you breast feeding at the present time?				
Do you have a disease, condition or problem not listed above?				

If yes, pleas describe:

Are you presently ill or under the care of a physician? Yes No

History of Hospitalizations? Yes No

Any Allergies? (including rubber/latex) Yes No

Medications presently taking, including aspirin (please list) Yes No

Family History: (Circle)		Occupation/Job:		
Heart Diseas	Cancer	Tobacco use: Y N (age started)	Type:	Packs per day:
Diabetes	Seizures	Alcohol consumption: Y N	Type:	Drinks per day:
None		Meth use Y N	Current ___ Past ___ Never ___	

PATIENT NAME: Sex M___ F___

DATE OF BIRTH: PHONE NUMBER:

PATIENT SIGNATURE:
(Parent/Guardian if Minor)

DATE:

Provider Notes:

Provider: Date:
_________ _________
_________ _________

PLEASE SIGN PRIVACY PRACTICES, ON THE BACK OF THIS SHEET