HEALTH HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____ **Sex:** □ M □ F **Age:** _____

Primary Doctor: _____

Vaccine: ☐ **Pneumonia** ☐ **Influenza** ☐**Covid-19** **Dates Administered:** _____

Do you currently have or have you ever had?

Eyes/Ears:

YES	NO	
□	□	Contact Lens Wearer – Type_____
□	□	Refractive Surgery (Lasik): date_____
□	□	History of injury – Type _____
□	□	Glaucoma
□	□	Hearing Loss R L Both
□	□	Hearing Aids? R or L / Both

Endocrine:

□	□	Thyroid: Hyper or Hypo
□	□	Diabetes – Insulin, pills, or diet controlled

Cardiovascular:

□	□	High Blood Pressure
□	□	Peripheral vascular disease
□	□	Atrial Fibrillation/Palpitations
□	□	Heart Attack: date _____
□	□	Murmur /history of Rheumatic fever
□	□	Chest pain/Angina – how often _____
		If yes, how treated _____
□	□	High Cholesterol
□	□	Pacemaker or Implanted defibrillator
□	□	History of Congestive Heart Failure
□	□	Heart surgery/coronary artery disease

Respiratory:

□	□	Asthma – last ER visit _____
□	□	COPD
□	□	Sleep Apnea
□	□	CPAP/BIPAP
□	□	Tuberculosis – treatment/year _____
□	□	Shortness of breath
□	□	Can you walk a flight of stairs without stopping?

Gastrointestinal:

□	□	Hiatal Hernia
□	□	Acid Reflex (GERD)
□	□	Hepatitis
□	□	Jaundice
□	□	Cirrhosis

Musculoskeletal:

□	□	Arthritis: Rheumatoid or Osteoarthritis
□	□	Back pain or Neck pain
□	□	Difficulty walking

Hematologic:

YES	NO	
□	□	HIV+
□	□	Anemia/Sickle cell – disease or trait
□	□	Bleeding/Easy bruising
□	□	Blood thinners
□	□	History of blood clots

Genitourinary:

□	□	Kidney Disease
□	□	Dialysis: Hemo/peritoneal (M T W TH F)
□	□	Overactive Bladder/ Incontinence
□	□	Prostate issues
□	□	*Ever* taken Flomax or Rapaflo, Tamsulosin?

Neurological:

□	□	Stroke or TIA – when _____
□	□	Panic / Depression / Anxiety
□	□	Paralysis – where _____
□	□	Parkinson's disease
□	□	Epilepsy – last seizures _____
□	□	Alzheimer's or Senile Dementia
□	□	Restless Leg Syndrome
□	□	other neurologic condition_____

Females:

□	□	Are you pregnant?
		Last menstrual period _____

Other:

□	□	Problems with Anesthesia
□	□	Cancer- what type _____
		Current treatment _____
□	□	Mastectomy: L or R? When_____
□	□	Do you smoke – how long _____
□	□	Alcohol use – how much _____
□	□	Substance abuse _____
□	□	Have you traveled in past three months? Where? _____
□	□	Have you or family member had fever with anesthesia?
□	□	Family Disease History: _____
		_____
		_____
		_____
		_____

TURN OVER

Please list all surgeries with approximate dates:

_____

_____

_____

_____

Allergies to medications:

MEDICATION / RESPONSE / SEVERITY

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____ /_____/_____

Allergic to: Latex/Rubber_____ Betadine/Iodine_____

Please include all prescriptions, over-the-counter, vitamins, and dietary supplements:

Medication	Dose	How Often		Medication	Dose	How Often