PLEASE FULLY COMPLETE FORM

HEALTH QUESTIONNAIRE

Name_____Birthdate_____Date_____

Married/Single/Widowed/Divorced_____Drug Allergies_____

PERSONAL MEDICAL HISTORY

__ High Blood Pressure__Diabetes__Heart Disease__Stroke__High Cholesterol__Angina__Ulcers__Acid Reflux

__Heart Valve Disorder__Irregular Heart Beat__Arthritis__Osteoporosis__Asthma__Allergies__Anemia

__Emphysema__COPD__Diverticulitis__Migraines__Glaucoma__Blood Disorders__Hepatitis__Thyroid

__Colon Problems__Hemorrhoids__Depression__Bipolar Disease__Prostate Disease__Hearing

Problems__Visual Problems___Cancer (What type) _____Other_____

PLEASE LIST ALL SURGERIES, HOSPITALIZATIONS AND YEAR OF THE EVENT AND ANY OTHER INFORMATION YOU WANT TO INCLUDE:

_____

_____

_____

_____**NONE:**_____

PLEASE LIST ALL MEDICATIONS YOU TAKE AND INCLUDE ANY OVER THE COUNTER MEDICATIONS:

_____

_____

_____

_____

_____**NONE:**_____

PLEASE CHECK ANY DISEASES YOUR PARENTS MAY HAVE HAD OR CIRCLE NONE: NONE

__Heart Disease__Diabetes__Cancer__Strokes

__High Blood Pressure__Osteoporosis__Asthma

__Allergies__Alcoholism__Seizures__Migraines

__Blood Disorders__Alzheimer's__Thyroid

__Arthritis__High Cholesterol__Mental Illness

PLEASE CHECK ANY DISEASES YOUR GRANDPARENTS MAY HAVE HAD OR CIRCLE NONE: NONE

__Heart Disease__Diabetes__Cancer__Strokes

__High Blood Pressure__Osteoporosis__Asthma

__Allergies__Alcoholism__Seizures__Migraines

__Blood Disorders__Alzheimer's__Thyroid

__Arthritis__High Cholesterol__Mental Illness

PERSONAL HABITS: PLEASE CIRCLE ALL THAT APPLY:

Do you smoke? Y/N If so, How much? _____ Do you dip or chew tobacco? Y/N

Do you drink alcohol? Y/N How much? Do you use recreational drugs? Y/N