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Health Questionaire

Confidential information required for our case history file. Please answer each question.

Are you in good health at the present time? Yes _____ No _____
If the answer is no, please explain_____
_____
Name of your personal physician: _____ Phone No:_____
Have you been under the care of any physician for any medical or surgical condition in the last five years? If so, please list the physician, conditions treated for and last general physical exam:_____
_____
Please list all surgery, including cosmetic surgery that you have had:_____
_____
Please list all medications that you are presently taking, including aspirin or Ibuprofen. Include all medications, prescription and non-prescription:_____
_____
Do you have any known drug allergies? If so, please list: _____
_____
Are you presently under psychological or psychiatric care? If so, please state therapist's name and length of treatment: _____
_____
Do you smoke? If so, how many pack(s) per day? _____
Do you drink alcohol? If so, approximately how much? _____
For Women: Is there a possibility that you are pregnant? _____
Have you ever had difficulties with anesthesia? _____

Have you had any of the following health issues?	**YES**	**NO**
Asthma, chronic Bronchitis or other lung problems:	_____	_____
Heart disease, including angina, arrythmias or prior heart attacks:	_____	_____
High blood pressure	_____	_____
Diabetes	_____	_____
Kidney disease	_____	_____
Hepatitis or other liver diseases	_____	_____
Peptic Ulcers	_____	_____
Migraine headaches	_____	_____
HIV or other communicable diseases	_____	_____
Cancer	_____	_____
Epilepsy	_____	_____
Lupus, scleroderma or other autoimmune disease	_____	_____

Other significant medical problems:_____
_____