HEALTH QUESTIONAIRE:

THIS FORM WILL BE SHREDDED ONCE IT IS TRANSFERRED TO THE SECURE ELECTRONIC CHART.

PATIENT NAME: ____

DO YOU TAKE ANY MEDICATIONS FOR ANY OF THESE CONDITIONS? IF YES, CHECK ☑THE BOX NEXT TO THE CONDITION AND WRITE THE MEDICATION & EXPLAIN ON THE ADJACENT LINE.

_____ I DO NOT TAKE ANY MEDICATIONS. Initial please.

☐Antibiotic ____
☐Pain Medicine ____
☐Heart Medicine ____
☐Aspirin (baby aspirin a day) ____
☐Cortisone/Steroids ____
☐Blood Thinner Meds(eg.Coumadin,Plavix,Aggrenox,Pradaxa) ____________________________
☐Blood Pressure Med/Cholesterol Med____
☐Hormone Therapy ____
☐Thyroid Meds ____
☐Birth Control Pills____
☐Insulin / Diabetes Med____
☐Ulcers / Acid Reflux____
☐Bone Density Medications (Bisphosphonates like Fosamax, Boniva, IV-Zometa, Actonel, Aredia)
____
☐Antidepressants____
☐Antianxiety Meds____
☐Cancer Meds____
☐Chemo Treatment and When____
☐Pre-Medication and Why and When____
☐OTHER Meds not listed?____

DO YOU HAVE ANY ALLERGIES OR ADVERSE REACTIONS? IF YES, CHECK ☑ THE BOX NEXT TO THE ITEM AND EXPLAIN.

______ I HAVE NO KNOWN ALLERGIES/REACTIONS

☐Penicillin ______________________________
☐Other Antibiotics ______________________________
☐Aspirin ______________________________
☐Sulfites ______________________________
☐Ibuprofen ______________________________
☐Codeine/Other Narcotics ______________________________
☐Local Anesthetic ______________________________
☐Latex Rubber ______________________________
☐Valium/ Halcion ______________________________
☐Nitrous Oxide ______________________________
☐Epinephrine: bad reaction? ______________________________
☐Metals ______________________________
☐Iodine / Seafood ______________________________
☐OTHER allergies ______________________________
☐OTHER reactions ______________________________

PATIENT NAME:____

ARE YOU ON ANY CURRENT MEDICAL TREATMENT OR DO YOU HAVE OR HAVE HAD ANY OF THESE CONDITIONS? CHECK ☑ THE BOX NEXT TO THE CONDITION AND WRITE YOUR STATUS.

_____I DO NOT HAVE ANY SIGNIFICANT MEDICAL CONDITIONS THAT I AM AWARE OF.

Under Physician's Care? Yes / No **Physician's Name__________________________**
Physician's Phone Number/EMAIL____

☐Current Medical Treatment ____
☐Hospitalized <5 years____
☐High Blood Pressure ____
☐Heart Disease ____
☐Pace Maker ____
☐Heart Murmur/Defect ____
☐Mitral Valve Prolapse ____
☐Angina / Other Heart Conditions____
☐Heart Attack/ Stroke and When _______________________________________
☐Alcoholism/Addiction ____
☐Smoke /Tobacco ____
☐Neurological Conditions ____
☐Migraine/Headaches ____
☐Epilepsy / Seizures ____
☐Mental Health / Anxiety / Depression ___________________________________
☐Immunocompromised ____
☐Kidney Disease / On Dialysis____
☐Liver Disease ____
☐Hepatitis ____
☐Implant-Organ/Prosthetic ____
☐Arthritis / Joint Conditions____
☐Joint/ Hip Replacement ____
☐Emphysema____
☐COPD____
☐Asthma / Other Lung Conditions_______________________________________
☐Cancer____
☐Radiation Therapy and Location and When________________________________
☐Chemotherapy____
☐Easily Winded/Fainting ____
☐Leukemia____
☐Ulcers / Digestive Conditions / Acid Reflux________________________________
☐Glaucoma / Eye Conditions____
☐Anemia / Bruise Easily____
☐Bleeding Disorders____
☐HypoThyroidism____
☐HyperThyroidism____
☐Diabetes / Low Blood Sugar / High Blood Sugar_____________________________
☐Hay Fever / Allergies____
☐Rheumatic Fever____
☐HIV____
☐Females: Pregnant? If yes, how many months? _________Or are you nursing?__________
☐OTHER CONDITION NOT LISTED HERE____