Health Questionnaire

Patient name: ____ DOB: __________________

Height: __________________ Weight: ____________________ Last Physical: ________________

Who will be responsible for picking you up and caring for you after surgery: ________________________
Phone #:____________________________

Please *type one*:

- Do/Did you ever smoke?______How many packs/day? __________ When quit? ________
- Use of alcohol: Never Rarely Moderate Daily
- Use of recreational Drugs: Never Rarely Daily
- Type of Drug: __________Frequency:________
- Excessive exposure at home/work to: Fumes Dust Solvents Airborne particles Noise Stress

Please *type yes or no*:

- Medication Allergies:_______ Please specify:____
- Environmental Allergies:_______Please specify:____
- Food Allergies:_____Please specify:____

Please list *all* that apply:

- Past medical History: Any problems, conditions or issues in the past or now?
  ____
  ____
- Past Surgical History: Any surgeries or procedures in the past or now?
  ____
  ____
- Any previous hospitalizations? Please include dates.
  ____
  ____
- Any decreased sensation in any parts of the body?
  ____
  ____
- Please list all medications that you take on the daily basis, including vitamins.
  ____
  ____
- Date of last Pap Smear _________________
- Date of last Mammogram________________
- Date of last Breast Exam_________________

Please check yes or no:

Constitutional Symptoms

Good general health lately	Yes	No
Recent weight change	Yes	No
Fevers	Yes	No
Fatigue	Yes	No
Headaches	Yes	No

Eyes

Eye disease or injury	Yes	No
Wear glasses/contact lenses	Yes	No
Blurred or double vision	Yes	No
Glaucoma	Yes	No

Ears/Nose/ Throat/ Mouth

Hearing Loss or ringing	Yes	No
Earaches or drainage	Yes	No
Chronic sinus problems/rhinitis	Yes	No
Nose bleeds	Yes	No
Mouth sores	Yes	No
Bleeding gums	Yes	No
Bad breath or bad taste	Yes	No
Sore throat or voice change	Yes	No
Swollen glands in neck	Yes	No

Cardiovascular

Heart condition	Yes	No
Chest Pain or angina pectoris	Yes	No
Shortness of breath (walking or laying)	Yes	No
Swelling feet, ankles or hands	Yes	No

Respiratory

Chronic or frequent coughs	Yes	No
Spitting blood	Yes	No
Shortness of breath	Yes	No
Asthma or wheezing	Yes	No

Gastrointestinal

Loss of appetite	Yes	No
Change in bowl movement	Yes	No
Nausea or vomiting	Yes	No
Frequent diarreha	Yes	No

Musculoskeletal

Joint pain or stiffness	Yes	No
Weakness in muscles/joints	Yes	No
Muscle pain or cramps	Yes	No
Back pain	Yes	No
Cold extremities	Yes	No
Difficult walking	Yes	No

Integumentary (skin, breast)

Rash or itching	Yes	No
Change in skin color	Yes	No
Change in nails or hair	Yes	No
Varicose veins	Yes	No
Breast pain	Yes	No
Breast lump	Yes	No
Breast discharge	Yes	No

Neurological

Frequent or recurring headaches	Yes	No
Light headed or dizziness	Yes	No
Head injury	Yes	No
Convulsions or seizures	Yes	No
Numbness or tingling	Yes	No
Tremors	Yes	No
Paralysis	Yes	No
Stroke	Yes	No

Psychiatric

Memory loss or confusions	Yes	No
Nervousness/anxiety	Yes	No
Depression	Yes	No
Insomnia	Yes	No

Endocrine

Glandular or hormone problem	Yes	No
Hypothyroid	Yes	No
Hyperthyroid	Yes	No
Diabetes	Yes	No
Excessive thirst/urination	Yes	No
Heat or cold intolerance	Yes	No
Skin becoming dryer	Yes	No

Change in hat or glove size	Yes	No

Genitourinary

Frequent urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Change in force of strain when urinating	Yes	No
Incontinence of dribbling	Yes	No
Kidney stones	Yes	No

Other: _____________________________

____

Hematologic/Lymphatic

Slow to heal after cuts	Yes	No
Bleeding or bruising tendency	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Past blood transfusion	Yes	No
Enlarged glands	Yes	No

Allergic/Immunologic

History of skin reaction or adverse reaction to any medications, food, or environmental, including gloves, latex or antibiotics	Yes	No

Please list all that apply and explain reaction that occurred____________

____

____

Patient signature:

____

Date:

____

Doctor's signature:

____

Date:

____