

HEALTH QUESTIONNAIRE

Please answer all questions on the following pages by placing a check mark in the appropriate YES or NO column. If necessary, write additional information in the Comment section.

Please list current medications (prescribed & OTC)	Please list any ALLERGIES:

DO YOU HAVE A HISTORY OF	YES	NO	DO YOU HAVE A HISTORY OF	YES	NO
Heart or Circulation Problems			Urinary, Kidney or Bladder Problems		
Heart murmur			Kidney stones		
Heart attack: Month/Year _____			Frequent urinary infections		
Irregular heart beat			Difficult urination		
High Blood Pressure			Unable to hold urine		
Low Blood Pressure					
Stroke or blood clots			Head or Neurologic Problems		
Anemia/sickle cell anemia			Seizure or black outs		
Angina/chest pain			Frequent headaches		
Bleeding problems			Weakness in an arm or leg		
Swollen ankles/legs					
Cardiac Cath, EKG, Stress Test			Endocrine or Metabolic Problems		
			Diabetes – Diet Controlled _____		
			I take Pills _____ I take Insulin _____		
Lung or Breathing Problems			Hypoglycemia/Low blood sugar		
Asthma – Last attack _____			Thyroid problems		
Bronchitis					
Pneumonia			Other Major Illnesses or Cancer -		
Chronic lung disease			List: _____		
Sleep apnea					
Shortness of breath			Do you have or did you ever have:		
If Yes, circle when: At rest / Climbing stairs / Walking Briskly			Physical disability/Arthritis		
Frequent cough			Difficulty walking		
If Yes, do you cough anything up?			Joint replacement		
Abnormal chest x-ray			Back problems		
TB / Pos PPD			Other _____		
Digestive, Stomach or Liver Problems					
Difficulty swallowing			Do you have:		
Hiatal hernia/Acid reflux			Dentures		
Ulcers			Chipped or loose teeth (Circle)		
Jaundice (yellow skin)			Bridgework or Partial Plate		
Hepatitis			Glasses		
Diarrhea/Constipation			Cataracts/glaucoma		
Other _____			Difficulty hearing		
			Difficulty speaking		

