Confidential Health Questionnaire

Allergies : _____

_____

Medications and herbal products: _____

_____

Previous illnesses: _____

_____

Previous surgeries or anesthetics: _____

_____

Disabilities: _____

	Yes	No		Yes	No
High blood pressure	☐	☐	Heart murmur	☐	☐
Heart problems	☐	☐	Rheumatic fever	☐	☐
Angina	☐	☐	Heart attack	☐	☐
Pacemaker	☐	☐	Blood clots	☐	☐
Heart valve replacement	☐	☐	Fainting	☐	☐
Stroke	☐	☐	Lung disease	☐	☐
Asthma	☐	☐	Seizures/epilepsy	☐	☐
Bleeding disorder	☐	☐	Are you on blood thinners?	☐	☐
Liver disease	☐	☐	Jaundice	☐	☐
Diabetes	☐	☐	Kidney disease	☐	☐
Joint replacement (hip/knee)	☐	☐	Reflux/heartburn	☐	☐
GI disease (IBS, colitis, diarrhea)	☐	☐	Muscle weakness	☐	☐
Radiation treatment	☐	☐	Biphosphanates (Fosamax, Actonel)	☐	☐
Are you pregnant?	☐	☐	Smoker (within the past year)	☐	☐
Street drugs	☐	☐	Alcohol	☐	☐
Sleep apnea/ snoring	☐	☐	Mental illness	☐	☐
Hepatitis(A,B,C)	☐	☐	HIV/AIDS	☐	☐
Prednisone in the last 6 months	☐	☐	Birth control pill	☐	☐
Do you have dentures?	☐	☐	Do you have body piercings?	☐	☐
Do you or any members of you family had any problems with anesthesia				☐	☐

HEIGHT: _____ WEIGHT: _____

Signature: _____ Date: _____