

Health Questionnaire

Surgeon's Name _____

Surgery / Procedure Date: _____

Name: _____ Age: _____ Height: _____ Weight: _____

Medical Doctor's Name: _____ Last Seen: _____

Cardiologist (if applicable) _____ Last Seen _____

Please answer the following questions to the best of your ability. Any other information you'd like to share regarding your health history or comments, please elaborate at the end of the questionnaire.

Do you have, or have you ever had, the following conditions, illnesses or symptoms?

PLEASE CIRCLE YOUR ANSWER?

Neurological:

Stroke	Yes	No
Mini Strokes	Yes	No
Seizures	Yes	No
Migraines	Yes	No
Fainting	Yes	No
Depression	Yes	No
Multiple Sclerosis	Yes	No
Developmental disability	Yes	No
Explain _____		

Respiratory:

Asthma	Yes	No
Shortness of Breath	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Pneumonia	Yes	No
Chronic Cough	Yes	No
Sleep Apnea	Yes	No
CPAP machine	Yes	No
Do you smoke?	Yes	No
How Much? _____ PPD		
Recent Cold or Flu?	Yes	No

Cardiac:

High Blood Pressure	Yes	No
Heart Attack? Date: _____	Yes	No
Angina / Chest Pain	Yes	No
Palpitations	Yes	No
Irregular Heart Beat	Yes	No
Heart Murmur	Yes	No
Heart Bypass Surgery	Yes	No
Date: _____		
Cardiac Angioplasty	Yes	No
Date: _____		
Pacemaker / Defibrillator	Yes	No
Date: _____ Where: _____		
Congestive Heart Failure	Yes	No

Urinary:

Kidney Disease	Yes	No
Kidney Stones	Yes	No
Dialysis	Yes	No

Endocrine:

Diabetes	Yes	No
Hypothyroidism	Yes	No
Hyperthyroidism	Yes	No

Liver / Gastrointestinal:

Hepatitis	Yes	No
Jaundice	Yes	No
Liver Disease	Yes	No
Cirrhosis	Yes	No
Hiatal Hernia	Yes	No
Heartburn	Yes	No
Acid Reflux	Yes	No
Do you drink alcohol?	Yes	No
How Much? _____		
Do you use recreational drugs?	Yes	No
How Often? _____		

Hematologic / Oncological:

Clotting Disorders	Yes	No
Anemia	Yes	No
Blood Clots in legs or lungs	Yes	No
History of Cancer? Where? _____		
Radiation Therapy	Yes	No
Chemotherapy	Yes	No

Allergies:

Please list medications, latex and environmental allergies. What type of reaction did you have?

Please list prior surgeries: _____

Have you had an anesthetic complication or is there a family history of anesthesia complications? _____

Pediatric Patients ONLY:

Was child born prematurely?	Yes	No
How many weeks premature? _____		
Any problems noted at birth? _____		

Completed by: _____ Today's Date: _____