HEALTH QUESTIONNAIRE

Name: _____

Age:_____ Sex:_____ Height:_____ Weight: _____ Date of Birth: _____/_____/_____

Please circle Yes or No.

1. Has there been any change in your health within the last year . . Yes No
   If yes, please explain:
   _____

2. Have you had any serious illness or operation . . . . Yes No
   If yes, please list:
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

3. Are you currently taking any prescribed or non-prescribed medications . Yes No
   If yes, please list:
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

5. Are you allergic to any medications . . . . . Yes No
   If yes, please list:
   _____ _____ _____
   _____ _____ _____

6. Do you have a past or family history of complications with anesthesia . Yes No
   If yes, please explain:
   _____

7. Do you smoke, vape, e-cigarette, or juul? . . . . . Yes No
   If yes, how much per day: _____

8. Do you have a history of drug or alcohol abuse? . . . . Yes No
   If yes, please explain: _____

9. Do you have, or have you had ***lung problems***?
   a. Asthma . . . . . Yes No
   b. Bronchitis, tuberculosis, or emphysema . . . . Yes No
   c. Other lung problems, please explain: _____

10. Do you have, or have you had ***stomach or intestinal problems***?
    a. Ulcers, blood in stool, black stools, or vomiting blood . . Yes No
    b. Frequent heartburn (reflux) . . . . . Yes No
    c. Other stomach or intestinal problems, please explain: _____
    d.

11. Do you have, or have you had ***kidney problems***?
    a. Frequent kidney or urinary tract infections . . . . Yes No
    b. Kidney stones . . . . . Yes No
    c. Blood in the urine . . . . . Yes No
    d. Other kidney problems, please explain:_____

12. Do you have, or have you had ***heart problems***?

a. Heart murmur or heart valve defect . . . . Yes No
b. Rheumatic fever or rheumatic heart disease . . . . Yes No
c. Heart valve replacement . . . . . Yes No
d. Congenital heart defect or problems . . . . Yes No
e. Do you have a pacemaker . . . . . Yes No
f. History of heart attack . . . . . Yes No
g. High blood pressure . . . . . Yes No
h. Low blood pressure . . . . . Yes No
i. Irregular or rapid heart beat . . . . . Yes No
j. Chest pains and/or shortness of breath . . . . Yes No
k. Swollen ankles or hands . . . . . Yes No
l. Artificial joints or prosthetics . . . . . Yes No
m. Other heart problems, please explain: _____

13. Do you have, or have you had the ***liver problems***?
a. Hepatitis or yellow jaundice . . . . . Yes No
b. Other liver problems, please explain: _____

14. Do you have, or have you had ***blood problems***?
a. Anemia . . . . . Yes No
b. Bleeding abnormalities . . . . . Yes No
c. Other blood problems, please explain: _____

15. Do you have, or have you had ***endocrine problems***?
a. Thyroid disorder . . . . . Yes No
b. Cortisone or steroid treatments . . . . . Yes No
c. Adrenal gland disorder . . . . . Yes No
d. Diabetes . . . . . Yes No
e. Other endocrine problems, please explain: _____

16. Have you been diagnosed with glaucoma . . . . . Yes No
17. Sinus trouble, hay fever, hives or skin rash . . . . . Yes No
18. Fainting spells, seizures, or epilepsy . . . . . Yes No
19. Arthritis or inflammatory rheumatism . . . . . Yes No
20. Gout . . . . . Yes No
21. Stroke. If yes, when: _____ . . . Yes No
22. Do you have HIV, immunity suppression, or auto-immune disadvantage or disorder Yes No
23. Have you had any head, neck, or jaw injuries . . . Yes No
24. Have you experienced any problems in your jaw, as
a. Clicking . . . . . Yes No
b. Pain in the joint, ear, or side of face . . . . . Yes No
c. Difficulty opening or closing your mouth, or chewing . . . Yes No

25. ***Women:*** Are you or might you be pregnant . . . . . Yes No

_____ Date: _____
Signature of Patient, Parent or Guardian

_____ Date: _____
Signature of Doctor

❒ Approved for surgery. ❒ Requires medical or medication consultation.