

HEALTH QUESTIONNAIRE

1. Do you have any allergies to drugs or foods? YES NO

Please list _____

2. Are you allergic to latex products? YES NO

3. Are you currently taking medications? YES NO

Please list _____

4. Do you have a family or other private physician? YES NO

Name of physician: _____

Address: _____ City/State/Zip code _____

5. **Please circle any of the following illnesses that you have had:** heart disease (murmur, heart failure, arrhythmia, heart attack), hypertension (high blood pressure), rheumatic fever, asthma, emphysema, tuberculosis, pneumonia diabetes, stomach ulcers, hepatitis, jaundice, anemia, stroke, seizures (convulsions)phlebitis (blood clots in veins), recurrent infection (bladder, prostate, kidney, sinus, respiratory, etc.), tumor or growth.

6. Have you had previous surgery? YES NO

Please list _____

7. Have you had problems with previous anesthesia? YES NO

8. Do you have sleep apnea? YES NO

a) Do you use a special mask or equipment at night to sleep? YES NO

9. Do you have any problems with abnormally easy bleeding? YES NO

10. Have you had any major trauma (fractures, etc.)? YES NO

Please list _____

11. Have you been hospitalized over the past two years? YES NO

If so, why? _____

12. Do you have any known contagious diseases? YES NO

13. Have you been tested for exposure to the AIDS virus? YES NO

14. **Women:** Are you pregnant? YES NO

15. Habits: Do you smoke? YES NO

Number of packs per day: _____ Number of years: _____

16. Do you use alcohol? YES NO

Please provide other health information you deem important:

SIGNATURE: _____

DATE: _____