

HEALTH QUESTIONNAIRE & MEDICAL INFORMATION

DO YOU HAVE OR HAVE YOU EVER HAD:

Specific Heart Diseases
Listed Below:

Heart Murmur	Yes	No
Arteriosclerosis	Yes	No
Angina	Yes	No
Congestive Heart Failure	Yes	No
Heart Attack	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Rheumatic Fever	Yes	No
Cholesterol Problems	Yes	No
Diabetes	Yes	No
Dry Mouth	Yes	No
Joint Replacement or Damage	Yes	No
Seizures	Yes	No
Fainting Spells	Yes	No
Stomach Ulcers	Yes	No
Kidney Problems	Yes	No

Sinus Trouble	Yes	No
Liver Problems	Yes	No
Anemia	Yes	No
Night Sweats	Yes	No
Unexplained Weight Loss/Fever	Yes	No
Blood Transfusion (Year ____)	Yes	No
Test for HIV for AIDS N/A	Pos	Neg
Test for TB N/A	Pos	Neg
Radiation Treatment (Year ____)	Yes	No
Chemotherapy (Year ____)	Yes	No
Cancer: (Please list type with year)	Yes	No

Surgery: (Please list with year) Yes No

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

Any local anesthetics	Yes	No
Aspirin/Anti-inflammatory drugs	Yes	No
Heart Medications	Yes	No
Insulin, Micronase, or Glucotrol	Yes	No

Codeine	Yes	No
Latex	Yes	No
Other Allergies: (Please list)	Yes	No

ARE YOU TAKING ANY OF THE FOLLOWING:

Anticoagulants (blood thinners)	Yes	No
Aspirin/Anti-inflammatory drugs	Yes	No
Heart Medications	Yes	No
Medicine for High Blood Pressure	Yes	No
Insulin, Micronase, or Glucotrol	Yes	No

Nitroglycerin	Yes	No
Antibiotics or Sulfa Drugs	Yes	No
Cortisone or Steroids	Yes	No
Tranquilizers or Antidepressant	Yes	No
Birth Control Pills	Yes	No

List Medications Currently Taking

Dosage

Freq

Reason

Please describe any current or recent medical treatment, impending operations, pregnancies, or other information we should be aware of: _____

ALL INFORMATION IS PROTECTED BY DOCTOR-PATIENT CONFIDENTIALITY. YOU WILL BE HELD RESPONSIBLE IF STATEMENTS OR REPRESENTATIONS ARE UNTRUE.