Health Questionnaire
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Please list **ALL MEDICATIONS** you are presently taking. _____ _____

_____ _____ _____ _____ _____

Please check **ALL MEDICATIONS or SUBSTANCES** you are **ALLERGIC TO** and the reaction you get when taking them.

PENICILLIN _____ CODEINE _____ ASPIRIN _____ NOVOCAINE _____ IODINE _____
FOODS _____ OTHER _____

Please list all surgeries and/or hospitalizations.

Do you have a history of sexually transmitted diseases? If so, what: _____

FAMILY HISTORY: Does anyone in your family have any of the following:

____Diabetes ____Arthritis ____Cancer ____Other Diseases

____Heart Valve Pathology ____Abnormal Heart Rhythm _____Heart Attack ____Stent

____Hypertension (high blood pressure) _____Stroke

SOCIAL HISTORY:

Occupation: _____

Do you drink Coffee_____ Alcohol_____ Tobacco _____?
(Cigarettes, E-cigs, Chew, Cigars)

REVIEW OF SYSTEMS:

EAR/EYES/NOSE/THROAT

____Headaches
____Seizures
____Convulsions
____Ringing in Ears
____Dizziness
____Hard of hearing
____Fainting Spells
____Sore Throat
____Blurred Vision
____Nausea/Vomiting
____Double Vision

RESPIRARTORY

____Shortness of Breath
____Sinus Infection
____Bloody Nose
___Chronic Cough

VASCULAR

____Chest Pain
____Palpitations
____Cramps
____Varicose Veins
____Problem with bleeding

URINARY

____Frequent Urination
____Blood in Urine
____Burning w/Urination

GASTROINTESTINAL

____Excessive thirst
____Blood in Stool
____Problem Swallowing
____Jaundice
____Gallstones
____Diarrhea
____Chronic Constipation

MUSCULOSKELETAL

____Joint Pain(specify)_____
____Joint Stiffness(specify)_____
____Weakness
____Stiffness (specify)_____
____ Problem scarring
____ Swelling feet/ankles
____ Numbness/ burning Feet/ankles

*****TO MY KNOWLEDGE, THE ABOVE INFORMATION IS CURRENT AND CORRECT*****

FEMALES: To your knowledge, **ARE YOU presently PREGNANT OR BREASTFEEDING?** YES ___ NO ___

_____ _____
Patient Signature Date