

GENERAL HEALTH QUESTIONNAIRE

NAME \_\_\_\_\_ DATE \_\_\_\_\_

The following information is very important to your health. Please take time to fully and accurately fill out this form. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

PLEASE CIRCLE AN ANSWER FOR THE FOLLOWING:

- Heart murmur or valve problems: NO YES \_\_\_\_\_
- Bleeding Disorder/easy bleeding: NO YES \_\_\_\_\_
- Hepatitis/jaundice: NO YES \_\_\_\_\_
- Diabetes: NO YES \_\_\_\_\_
- Skin cancer: NO YES \_\_\_\_\_
- Colitis or other bowel disease: NO YES \_\_\_\_\_
- Hay fever or asthma: NO YES \_\_\_\_\_
- History of positive TB test: NO YES \_\_\_\_\_
- High blood pressure: NO YES \_\_\_\_\_
- Do you have a pacemaker: NO YES \_\_\_\_\_
- Artificial joints or heart valve: NO YES \_\_\_\_\_
- Allergy to anesthetics: NO YES \_\_\_\_\_
- Female: Could you be pregnant at this Time: NO YES \_\_\_\_\_

**\*If nothing applies to the following three categories please apply NA or NO.**

Please list any chronic or serious illnesses, hospitalizations or operations:

Are you allergic to any medications:

Please list any medication that you are currently taking, including any non-prescription drugs as well:

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

The above information is true and correct.