MEDICAL HISTORY QUESTIONNAIRE

PLEASE TAKE TIME TO CAREFULLY FILL OUT THIS QUESTIONNAIRE.
USE THE BACK OF THIS FORM FOR ADDITIONAL COMMENTS.

Patient's Name: _____ Date of Birth:_____/_____/_____ Age:_____ Weight:_____lbs.

1. Are you in **good health?** _____ YES NO
2. Are you pregnant, or could you be pregnant? _____ YES NO
3. Are you a **smoker?** _____ YES NO
4. Do you drink alcohol? If so, how many drinks per week? _____ YES NO
5. Are you regularly under the care of a physician? _____ YES NO
6. Have you had any serious illnesses, accidents, operations, or been hospitalized in the last 5 years? YES NO
   Please list: _____
7. Have you had in the past any of the following **heart diseases or complications?** YES NO
   Check all that apply: ☐Congenital heart defects, ☐Murmurs, ☐Malfunctioning heart valves,
   ☐Pacemaker, ☐arrhythmia or irregular heartbeats, ☐Ventricular or Atrial Septal defects?
8. Do you have or had in the past any of the following **cardiovascular (heart) complications?** YES NO
   ☐arrhythmia or irregular heartbeats, ☐Ventricular or Atrial Septal defects? _____
   Check all that apply: ☐Chest pain or cyanosis upon exertion, ☐Shortness of breath on exertion,
   ☐High blood pressure, ☐Stroke, ☐recurrent fainting? _____
9. Have you had a recent **nose, throat, chest cold or flu?** _____ YES NO
   a. How long has it been fully resolved? _____ (days/weeks)
   b. Are there continued symptom's (examples: cough, fever, nasal discharge? YES NO
10. Do you have or had in the past any of the following **lung diseases or complications?** YES NO
    Check all that apply: ☐Bronchitis, ☐Pneumonia, ☐Chronic cough, ☐Chronic sinus disease,
    ☐Seasonal allergies
11. **Have you ever had asthma?** YES NO
    a. When was the last attack? _____ (weeks/months/years)
    b. How severe and how often do the attacks occur? _____
    c. Do you need daily asthma medication or do you just use the medication as needed?
    d. Have steroid medications ever been used? If so, how often? Last use? YES NO
12. Have you ever been diagnosed with **Sleep Apnea** or is there loud snoring every night when sleeping? YES NO
13. Do you have or had in the past any of the following diseases or complications? YES NO
    a. Liver (Hepatitis, Jaundice) YES NO
    b. Kidney (Kidney stones, ureter or bladder disorders, renal insufficiency or failure) YES NO
    c. Thyroid disease or Diabetes YES NO
    d. Stomach problems (ulcers, excess stomach acid, reflux, persistent diarrhea, or weight loss) YES NO
    e. Arthritis (swollen or painful joints or lymph nodes) YES NO
    f. Muscle disorders or weakness (low muscle tone, muscular dystrophy) YES NO
    g. Seizures, Fainting spells, Frequent Headaches, or other neurological problems? YES NO
    h. Depression, ADHD, Autism, PDD, or any other problem with mental health? YES NO
    i. Cancer YES NO
14. Do you **bruise easily** or have you **ever been diagnosed with a bleeding disorder?** YES NO
15. Do you have any **blood disorders** such as Anemia or Sickle Cell Anemia? YES NO
16. Has any blood relative of the patient ever had a **bad or unusual reaction to anesthesia?** YES NO
17. Do you have any disease, disorder, or complications not mentioned above? YES NO
    If yes, please explain: _____

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed the above medical Health history carefully and have answered all questions truthfully and to the best of my knowledge.

Signature: **Printed Name:** **Date: / /**