HEALTH INFORMATION

DATE _____ NAME _____ D.O.B. _____

HEALTH QUESTIONARE SELECT ALL THAT APPLY:

Diabetes: ❑ insulin ❑ pills ❑ diet
❑ Seizures
❑ Stroke
❑ High blood pressure
❑ Arthritis
❑ Kidney Disease
❑ Abnormal Bleeding
❑ Hepatitis
❑ Asthma
❑ Heart disease
❑ Psychiatric Disease
❑ Anxiety
❑ Other _____

PAST SURGERY:

❑ CABG
❑ Stomach
❑ Hernia
❑ Hysterectomy
❑ Colon
❑ Tubal Ligation
❑ C section
❑ Appendix
❑ Spine
❑ Other _____
❑ Breast
❑ Hip ❑ Knee

FAMILY HISTORY:

❑ Heart Attacks
❑ Cancer
Father ❑ alive ❑ dead age _____
❑ Diabetes
❑ Bleeding disorder
Cause of death _____
❑ High Blood Pressure
❑ Kidney Disease
Mother ❑ alive ❑ dead age _____
❑ Other _____
Cause of death _____

SOCIAL HISTORY:

Family & Friends any living nearby to support & assist during convalescence? ❑ YES ❑ NO

Living arrangements: ❑ Alone ❑ with family ❑ board and care home

Smoke ❑ Yes ❑ Less than 1 pack per Day ❑ Grater than 1 pack per day Yrs. _____ ❑ No ❑ Quit _____ Yrs.

Alcohol Consumption: ❑ NONE ❑ Occasionally ❑ Socially ❑ Regularly ❑ #drinks per day _____

Recreational drugs: ❑ Marijuana ❑ Amphetamines ❑ Cocaine ❑ Heroin ❑ Other _____

CURRENT MEDICATION:

Name of Medication	Dose	Frequency

Do you take diet pills: ❑ Herbal Supplements ❑ anticoagulants? If so list them.

_____

Medication Allergies: _____

Will you accept blood transfusion? ❑ Yes ❑ No

Pharmacy you currently use for medication _____