General Health Questionnaire

Name: _____ **Date:** _____

Height: _____ **Weight:** _____

What are you being seen for today? _____

Please check if you have any of the following medical conditions:

- ◯ Cancer
- ◯ Asthma
- ◯ Bleeding problems
- ◯ Kidney Failure
- ◯ Diabetes
- ◯ Heart Disease
- ◯ Lung Disease
- ◯ Stomach Ulcers
- ◯ Infection
- ◯ Blood Clot – DVT
- ◯ High Blood Pressure
- ◯ Fainting spells
- ◯ Stroke
- ◯ Gallbladder Disease
- ◯ Other: _____
- ◯ Arthritis
- ◯ Hepatitis
- ◯ Aids/HIV
- ◯ Psychiatric Illness

Do any of the above conditions run in your family: ◯ No ◯ Yes
List: _____

Please list all current medications:

_____

_____

_____

Are you currently taking any "blood thinners"? ◯ No ◯ Yes (list) _____

List any allergies to medication: _____

Please list all surgeries you have had:

_____

_____

Please list any other hospitalizations you have had:

_____

_____

Have you or a family member ever had problems with anesthesia? ◯ No ◯ Yes

Do you smoke? ◯ No ◯ Yes How much? _____
Do you drink alcohol? ◯ No ◯ Yes How much? _____

Please check if you have any of the following:

- ◯ Fever
- ◯ Shortness of Breath
- ◯ Skin rash
- ◯ Neck pain
- ◯ Abdominal Pain
- ◯ Loss of balance
- ◯ Headache
- ◯ Diarrhea
- ◯ Depression
- ◯ Chest pain
- ◯ Urinary incontinence
- ◯ Back pain