Health Questionnaire

Name:_____

Age: _____ Height: _____ Weight: _____

	YES	NO
Have you been hospitalized in the past 2 years?		
Have you been treated for any medical problems in the past 2 years?		
Are you currently taking any medications at this time? If yes, please list them on the reverse side.		
Are you allergic to penicillin?		
Are you allergic to codeine or other narcotics?		
Are you allergic to latex?		
Are you allergic to any other medications or substances?		
Have you ever had excessive bleeding following dental treatment or at any other time?		
WOMEN: Are you pregnant?		

Please check any of the following that you have had:

☐ Heart trouble	☐ Hepatitis	☐ Epilepsy
☐ Heart murmur	☐ Kidney disease	☐ Venereal disease
☐ Rheumatic Fever	☐ Tuberculosis	☐ Ulcers
☐ High Blood Pressure	☐ Respiratory problems	☐ Artificial heart valves
☐ Diabetes	☐ Sinus problems	☐ Artificial joints
☐ HIV +/AIDS	☐ Cancer	☐ Lupus

Is there anything else in your health history that may be significant?

_____
_____
_____

Date: _____Signature: _____