HEALTH HISTORY QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history. Please fill out as much of this questionnaire as possible. Thank you for your help.

NAME: _____

HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____

Please list all medications:

_____ _____

_____ _____

Please list any medication allergies or reactions:

_____ _____

_____ _____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery/reason for hospitalization/location *Date*

_____ _____

_____ _____

_____ _____

Answer yes or no to the following:

Require assistance to get around ☐ Yes ☐ No

Lose your balance ☐ Yes ☐ No

Anaphylaxis or shock in/out of operating room ☐ Yes ☐ No

Asthma, seasonal hay fever, or allergic rhinitis ☐ Yes ☐ No

Rashes, eczema, cellulitis, chronic open sores ☐ Yes ☐ No

Heart issues ☐ Yes ☐ No

Food allergies ☐ Yes ☐ No If yes, please list. _____

Allergy to latex or rubber products ☐ Yes ☐ No

Answer yes or no if you have allergic symptoms to any of the following:

Latex gloves ☐ Yes ☐ No

Blowing up balloons ☐ Yes ☐ No

During dental exams ☐ Yes ☐ No

During pelvic or rectal exams ☐ Yes ☐ No

During contact with diaphragms or condoms ☐ Yes ☐ No

Please check yes or no if you or a family member has a history of the following:

	Yes	No
Unexpected deaths following general anesthesia		
Unexpected deaths following exercise		
Malignant hyperthermia		
Muscle or neuromuscular disorder		
High temperature following exercise		

Please check yes or no if you have a personal history of the following:

	Yes	No
Muscle spasm		
Dark or brown colored urine		
Unanticipated fever immediately following anesthesia		
Unanticipated fever immediately following exercise		
MRSA (Methicillin-resistant Staphylococcus aureus)		
Sleep Apnea If yes, do you use a CPAP?		