

HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Chief Complaint

Reason for today's visit? _____

Current problem is the result of a(n): **Check all that apply**

Car Accident Work Accident Accident Other _____

Past History

Please list any major illnesses and/or injuries:

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? Yes No

Current Medication(s)	Dose	Frequency

ALLERGIES TO MEDICATIONS: