HEALTH QUESTIONAIRE

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: