Wayne R. Kirkham, M.D.

HEALTH QUESTIONNAIRE

NAME:_____ DATE:_____

1) What is the problem or complaint?

2) How long have you had this problem?

3) What makes it better?

4) What makes it worse?

5) Is there a family history of this?

6) Have you had any surgery? No Yes

PLEASE LIST ALL:

7) **FEMALES ONLY:** Are you pregnant? No Yes

8) Please list all medications you are taking, prescription and over the counter:

9) Any medication allergies? No Yes

PLEASE LIST IF YES:

10) Tobacco (any form)? No Yes Kind and amount: _____

11) Alcohol intake? No Yes Amount:_____

12) Past illnesses or hospitalizations (explain if yes):

Heart:	No	Yes_____
Lung:	No	Yes_____
Kidney or Bladder:	No	Yes_____
Neurological/Stroke:	No	Yes_____
High Blood Pressure:	No	Yes_____
Diabetes:	No	Yes_____
Thyroid Disease:	No	Yes_____
Bleeding Problem:	No	Yes_____
Glaucoma:	No	Yes_____
Stomach, Liver, Bowel Problem:	No	Yes_____
Cancer:	No	Yes_____
HIV:	No	Yes_____
Personal or Family History of Anesthesia Problem:	No	Yes_____

Patient Signature (or Parent):_____ WRK:_____