MEDICAL HISTORY AND HEALTH QUESTIONAIRE

1. How would you describe your general health ? ☐Excellent ☐Average ☐ Poor

2. Height_____ Weight_____

3. Date of last medical examination:_____

4. List previous surgeries you have had and the date you had the surgery/surgeries:

_____

_____

_____

5. Are you taking any medications or drugs at present? If so, what?_____

_____

6. Do you smoke?_____If so, how much?_____

7. Allergies? To what?_____

Do you have or have you ever had any of the following:

	YES	NO
Heart disease		
Shortness of breath with limited activity Or when resting?		
Chest pain or angina pectoris		
Heart attack		
Rheumatic fever or rheumatic heart disease		
Heart murmor		
Heart defect from birth		
High blood pressure		
Fainting spells, convulsions or epilepsy		
Lung disease (tb, asthma, jaundice, cirrhosis or other)		
Liver disease (hepatitis,		

jaundice,cirrhosis or other)		
Kidney disease		
Diabetes		
Prolonged bleeding following injuries or surgery		
Skin diseases		
Psychiatric problems eg depression		

8. Do you have any family history of these diseases? Please explain

_____

_____

.9. Did you get referred to our office by a physician?_____

If so, please provide the name of the physician_____

City of referring physician_____

10. Do you now or have you in the past month taken any aspirin? _____

11. Is there anything of importance in your medical history that has not been asked?

_____

_____

12. Explain:_____

I HEREBY GIVE MY PERMISSION TO M.J. PLACE, M.D. TO ADMINISTER ANY TREATMENT; OR TO ADMINISTER SUCH ANESTHETICS; AND TO PERFORM SUCH OPERATIONS THAT MAY BE DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREATMENT OF THE PATIENT NAMED BELOW.

PATIENT SIGNATURE :_____**DATE:**_____

_____RELATIONSHIP_____

(SIGNATURE OF PATIENT OR NEAREST RELATIVE)

AUTHORIZATION MUST BE SIGNED BY THE PATIENT, OR BY THE NEAREST RELATIVE IN THE CASE OF A MINOR OR WHEN THE PATIENT PHYSICALLY OR MENTALLY INCOMPETENT.