HEALTH QUESTIONNAIRE

Are you presently ill or under the care of a physician? Yes ____ No ____
If yes, please describe: _____
_____

History of hospitalizations: _____
_____

Any family history of: (circle) Heart Disease Diabetes Cancer Seizures

Your social history: Tobacco Use: Yes____ No____ Frequency: _____
Alcohol Consumption: Yes____ No____ Frequency: _____

Do you have or have you had any of the following medical conditions?

Check each item	*Yes*	*No*			*Yes*	*No*
Current medical treatment				***ALLERGIES TO:***		
Heart condition				**Antibiotics**		
High blood pressure				**Aspirin**		
Respiratory/Asthma				**Tylenol**		
Mitral valve prolapse				**Ibuprofen**		
Immunocompromised				**Codeine**		
Anemia/Bleeding				**Narcotics**		
Diabetes/Kidney disease				**Local Anesthesia**		
Herpes				**Latex**		
Thyroid/Hormonal				**Sulfa**		
Liver disease				**Other:**		
Hepatitis – Type A, B, C						
Ulcers/Digestive				***MEDICATION PRESENTLY TAKING:***		
Migraine/Headaches						
Epilepsy/Fainting						
Glaucoma/Visual						
Mental/Neural						
Tumor/Neoplasms						
Alcoholism/Addiction						
Infectious diseases						
Venereal disease						
Prosthetic joints						
HIV						
TMD						
Bruxism (grinding)						

Do you have any disease, condition or problem not listed above? If yes, please describe below:
_____
_____

Have you ever been told that you should not donate blood? Yes _____ No_____
Do you need to pre-medicate? Yes _____ No_____

Females: Are you pregnant as this time? Yes _____ No _____
Are you presently on birth control? Yes _____ No _____

No Changes_____

_____
Patient's Signature Date