

## HEALTH QUESTIONNAIRE

NAME \_\_\_\_\_ AGE \_\_\_\_ HT. \_\_\_\_ WT \_\_\_\_ DATE \_\_\_\_\_

List all major medical illnesses you have had:

LATEX ALLERGY: YES\_\_\_\_ No\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all Operations you have had:

Type of Anesthesia:      Approximate Date of Operation:


	NO	YES	COMMENTS
1. Have you ever had a problem with anesthesia?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Has anyone related to you ever had a problem with anesthesia?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Could you be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Date of last menstrual cycle if applicable.			_____
5. Do you smoke? If so, how many packs per day? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Do you have a cough? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Do you bring anything up when you cough?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Have you ever tested positive for TB?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Have you had asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Do you have a cold?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Do you get short of breath after walking up two flights of stairs?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Have you had any difficulties with breathing?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Have you ever had an abnormal chest x-ray?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. To your knowledge have you been exposed to someone with TB?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

**QUESTIONNAIRE CONTINUED (PLEASE COMPLETE)**

	NO	YES	COMMENTS
15. Any unexplained fever, cough, night sweats lasting longer than 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	_____

16. Results of last TB test and when was it? \_\_\_\_\_
17. Do you have any bleeding tendencies?.....   \_\_\_\_\_
18. Have you ever been anemic?.....   \_\_\_\_\_
19. Do you have a heart murmur?.....   \_\_\_\_\_
20. Have you ever had a heart attack?.....Year? \_\_\_\_\_   \_\_\_\_\_
21. Have you ever had angina or pain in the chest related to your heart? ...   \_\_\_\_\_
22. Have you ever had high blood pressure?.....   \_\_\_\_\_
23. Do you have diabetes?.....   \_\_\_\_\_
24. Have you had significant weight loss in the past 4 months without dieting?   \_\_\_\_\_
25. Have you ever had thyroid problems?.....   \_\_\_\_\_
26. Have you ever had epilepsy, seizures or fainting?.....   \_\_\_\_\_
27. Do you have frequent headaches?.....   \_\_\_\_\_
28. Have you ever had eye problems?.....   \_\_\_\_\_
29. Do you wear contact lenses?.....   \_\_\_\_\_
30. Have you ever had kidney disease?.....   \_\_\_\_\_
31. Have you ever had jaundice?.....   \_\_\_\_\_
32. Have you ever had hepatitis?.....   \_\_\_\_\_
33. Do you have any arm, leg or back problems?.....   \_\_\_\_\_
34. Do you have arthritis?.....   \_\_\_\_\_
35. Do you have any physical disabilities?.....   \_\_\_\_\_
36. Do you have chipped or loose teeth? Dentures, caps, bridgework, braces?   \_\_\_\_\_
37. Are you prone to infections?.....   \_\_\_\_\_
38. Do you have a problem with prolonged healing time?.....   \_\_\_\_\_
37. Are you extremely anxious about your pending surgery if applicable?.....   \_\_\_\_\_
38. Any present illness not mentioned above?.....   \_\_\_\_\_
39. Are you being treated for sleep apnea?.....   \_\_\_\_\_
40. If surgically necessary, would you allow your doctor to use donor blood, bone, or other foreign objects in the treatment of your condition? .....   \_\_\_\_\_
- If no, please state why \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HEALTH QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please briefly describe the problem for which you are here today and mark the spot where the problem is on the diagram below \_\_\_\_\_

\_\_\_\_\_

Please describe any treatments you have had to date: \_\_\_\_\_

\_\_\_\_\_

Any history of previous breast biopsies? **Yes/ No**

Comments: \_\_\_\_\_

Any past personal history of breast cancer? **Yes/ No**

Comments: \_\_\_\_\_

Family history of breast cancer? **Yes/ No**

Comments: \_\_\_\_\_

How old were you when you began menstruating? \_\_\_\_\_

What is the date of your last menstrual period? \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_ How many live births? \_\_\_\_\_

Age of first pregnancy? \_\_\_\_\_

Did you breastfeed? **Yes/ No** If so, for how long? \_\_\_\_\_

Have you used oral contraceptives? **Yes/No** Hormone replacement therapy? **Yes/ No**

\_\_\_\_\_  
Nahid Hamoui, M.D.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### **List of Medications:**

(List your prescribed drugs and any over-the-counter drugs, such as vitamins & inhalers.)

<b>Name of Drug</b>	<b>Strength</b>	<b>Frequency Taken</b>

### **Allergies to Medications:**

<b>Name of Drug</b>	<b>Reaction you had:</b>