General Health Questionnaire

Patient:________________________________Date:____

Reason for today's visit:____

Date of last physical exam (if known):____

Are you currently under a physician's care? YES NO
If yes, for what condition(s):____

Name of my physician(s):____

PLEASE CIRCLE YES OR NO FOR EACH OF THE FOLLOWING (PLEASE ANSWER ALL QUESTIONS)

Condition			Condition		
Anemia/Thin Blood	YES	NO	Heart Murmur	YES	NO
Angina/Chest pain	YES	NO	Hepatitis/Liver	YES	NO
Arthritis	YES	NO	High Blood Pressure	YES	NO
Artificial joint replacement	YES	NO	Immune Deficiency	YES	NO
Asthma	YES	NO	Kidney or Dialysis	YES	NO
Bleeding problems	YES	NO	Mitral valve prolapsed	YES	NO
Bronchitis	YES	NO	Osteoporosis	YES	NO
Cancer	YES	NO	Psychiatric therapy	YES	NO
Convulsions/seizures	YES	NO	Rheumatic fever	YES	NO
Cough/Cold presently	YES	NO	Stomach Ulcer	YES	NO
Diabetes	YES	NO	Stroke/Weakness	YES	NO
Emphysema	YES	NO	Thyroid problems	YES	NO
Glaucoma	YES	NO	TMJ problems	YES	NO
Heart Attack	YES	NO	Tuberculosis	YES	NO

Any other medical problems not listed above:____

Personal/family history of unusual reactions to anesthesia or surgery? YES NO
If YES, please describe:____

Medication allergies			Other Allergies:		
Aspirin	YES	NO	Sulfite preservatives	YES	NO
Codeine	YES	NO	Latex	YES	NO
Iodine	YES	NO	Soy	YES	NO
Penicillin	YES	NO	Other: ____		
Sulfa	YES	NO			

WOMEN: On birth control pills? YES NO
(antibiotics may interfere with these medications)
Currently nursing? YES NO
Are you pregnant? YES NO
Do you wish to consult your physician to rule out pregnancy before your surgery? YES NO

Previous radiation therapy to the head/neck region? YES NO
Recent cortisone/steroid therapy (orally)? YES NO

Operations/hospitalizations:____

Medications-pills-herbal remedies:____

Any other issues that need to be discussed with the Doctor?_____________________________________

The above information is correct to the best of my knowledge:

Signature:____Date:______________________________________