Martin | Gutowski

Confidential Health Questionnaire

Name _____ Today's Date _____

Age _____ Date of Birth _____ Email _____

Address _____ City_____ ZIP _____

Phone Number _____

Emergency Contact _____ Phone Number _____

Primary Care Physician _____ Phone Number _____

Reason for visit: _____

MEDICAL INFORMATION

Allergies □ None
□ Medications _____ Reaction _____
□ Environmental _____ Reaction _____
□ Latex Reaction _____

Medications (including dietary supplements, nonprescription and herbal products)

Past Medical History (list any past or current medical problems)

□ Cold sores or herpes infections

Past Surgical History (list any past procedures & operations, including complications)

□ Implant, pacemaker, defibrillator, or implantable medical device

Social History

Current Occupation _____
Do you smoke or use tobacco? No Yes
Packs per day _____
Year started _____Year stopped _____
Do you drink alcohol? No Yes
Drinks per week _____
Do you use recreational drugs? No Yes

Marital Status: Married Single Widowed
Number of children _____
Will any dependents rely on you after surgery? _____
Are you planning on having more children? _____
Who will care for you after surgery? _____
Loss of pregnancies or spontaneous abortions _____

Family Medical History (please explain if any of these conditions have affected a blood relative)
□ Cancer □ Breast Disease □ Heart disease (heart attacks, heart bypass surgery) □ Abnormal reaction to anesthesia

Bleeding or Blood Clotting Disorders
Have you or any blood relative had problems with:
□ Abnormal or excessive bleeding
□ Abnormal or excessive blood clotting, also called Deep Venous Thrombosis (DVT) or Pulmonary Emboli (PE)

Do you have now, or have you been diagnosed as having (if yes, please explain)

□ Stroke
□ Thyroid disease
□ Anemia
□ Arthritis
□ Cancer or tumor
□ Diabetes mellitus
□ Heart attack
□ Heart failure
□ Kidney disease
□ Easy bruising
□ Asthma
□ Varicose veins
□ Seizures
□ Palpitations
□ Hepatitis
□ Stomach or duodenal ulcer
□ Stomach or intestinal bleeding
□ Irregular or rapid heart beat
□ High blood pressure
□ Frequent gum or nose bleeds
□ Angina or chest pain
□ Jaundice or liver disease
□ Mood disturbance
□ Heart murmurs
□ Shortness of breath or wheezing
□ Frequent heartburn or reflux
□ Fainting or dizziness
□ Nervous breakdown
□ AIDS or HIV positive
□ Immune disorders

Height _____ **Weight** _____ **lbs**

How did you hear about our practice?

□ Internet search □ Doctor □ Friend □ Other _____
□ Television □ Magazine □ Web site _____

Who can we thank for this referral? _____

Completed by _____ **Signature** _____

Section below to be completed by physician

Physical Exam:

Impression:

Recommendations:

Signature _____ **Date** _____