ValleyHealth
Warren
Surgical Associates

HEALTH QUESTIONNAIRE

Name: ______________________________ Date Today: ____________________

Name of your Primary Care Physician: ______________________________

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

Heart attack ☐
High blood pressure ☐
Shortness of breath ☐
Emphysema ☐
Stomach ulcers ☐
GERD (gastroesphogeal reflux disease) ☐
IBS (irritable bowel syndrome) ☐
Hemorrhoids ☐
Hepatitis ☐
Bleeding disorder ☐ What kind ____________________
Kidney disease ☐
Thyroid disease ☐ hyperthyroid ☐ or hypothyroid ☐
Glaucoma ☐
Cancer ☐ What kind ____________________
HIV (human immunodeficiency virus) ☐ diagnosed when ____________________
Other not listed ____________________

CHF (congestive heart failure) ☐
Stroke (CVA) ☐
COPD (chronic obstructive pulmonary disease ☐
Diabetes ☐
Acid reflux ☐
Hiatal hernia ☐
Constipation ☐
Anemia ☐
Blood Clots ☐ Where ____________________
Arthritis ☐

List operations you have had and approximate dates (If no operations, mark here ☐).

____
____
____
____

Have you or a family member had unusual reactions to anesthetics? ☐ Yes ☐ No
Explain ____________________

Do you smoke? ________ Packs per day______ Do you chew tobacco or snuff?________
Do you drink alcohol? ________ How much and how often? ____________
Have you ever had a blood transfusion? ________ When____________
Why____________________

(PLEASE TURN OVER AND FILL OUT BACK)

FAMILY HISTORY:

Mother: (Living/Deceased) (List Medical Illnesses) (Type of cancer if any)

____

Father:

____

Brother(s):

____

____

Sister(s):

____

____

Grandparents:

____

____

Have you had any of these screenings:

Colonoscopy: Approximate date ____________________

Mammogram: Approximate date ____________________

Pap Smear: Approximate date ____________________

________________________________ ____________

Patient's Signature **Date**

________________________________ ____________

Physician's Signature **Date**