connecticutsurgicalarts,llc

Richard J. Martin, M.D., D.M.D.

159 SACHEM STREET
NORWICH, CT 06360

HEALTH HISTORY QUESTIONNAIRE

DATE_____

PATIENT NAME_____AGE_____

HEIGHT_____WEIGHT_____

FAMILY PHYSICIAN_____ ADDRESS_____

FAMILY DENTIST_____ADDRESS_____

FOR WHAT REASON ARE YOU SEEKING TREATMENT_____

FOR THE FOLLOWING QUESTIONS, CIRCLE YES OR NO, WHICHEVER APPLIES. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

1. ARE YOU IN GOOD HEALTH?.....YES NO
2. HAS THERE BEEN ANY CHANGE IN YOUR HEALTH SINCE LAST YEAR?.....YES NO
3. HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION OR HOSPITILIZATION WITHIN THE PAST FIVE YEARS?.....YES NO
   a. IF YES, PLEASE LIST ILLNESS OR OPERATION AND YEAR_____
   _____
4. DO YOU HAVE (NOW OR IN THE PAST) ANY OF THE FOLLOWING CONDITIONS:
   a. HEART DISEASE OR HEART ATTACK.....YES NO
      1) CHEST PAIN ON EXERTION (ANGINA).....YES NO
      2) SHORTNESS OF BREATH AFTER MILD EXERCISE.....YES NO
      3) DO YOUR ANKLES SWELL.....YES NO
   b. RHEUMATIC HEART DISEASE.....YES NO
   c. HEART MURMURS, DAMAGED HEART VALVES OR ARTIFICIAL HEART VALVES.....YES NO
   d. HIGH BLOOD PRESSURE.....YES NO
   e. STROKE.....YES NO
   f. ASTHMA OR HAY FEVER.....YES NO
   g. TUBERCULOSIS.....YES NO
   h. DIABETES.....YES NO
   i. HEPATITIS, JAUNDICE OR LIVER DISEASE.....YES NO
   J. KIDNEY DISEASE OR INFECTION.....YES NO
   k. ABNORMAL BLEEDING.....YES NO

SEE REVERSE SIDE FOR FURTHER INSTRUCTIONS

l. ANEMIA OR NEED FOR A BLOOD TRANSFUSION.....YES NO

m. EPILEPSY OR NEUROLOGIC DISORDER.....YES NO

n. FAINTING SPELLS OR SEIZURES.....YES NO

o. PROBLEMS OF THE IMMUNE SYSTEM.....YES NO

p. CHRONIC FATIGUE, NIGHT SWEATS, CHRONIC COUGH OR RECURRENT MOUTH SORES.....YES NO

q. THYROID PROBLEMS.....YES NO

r. RESPIRATORY PROBLEMS, EMPHYSEMA, BRONCHITIS, ETC. .....YES NO

s. STOMACH ULCER OR HYPERACIDITY.....YES NO

t. PROSTHETIC REPLACEMENT (KNEE, HIP, ETC.).....YES NO

u. CANCER OR TREATMENT FOR A TUMOR OR GROWTH.....YES NO

5. ARE YOU CURRENTLY TAKING ANY DRUGS, PILLS OR MEDICINE (INCLUDING NON-PRESCRIPTION).....YES NO

a. IF YES, PLEASE LIST MEDICATION AND DOSE:_____
_____
_____

b. DO YOU TAKE ASPIRIN ON A REGULAR BASIS.....YES NO

5. ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

a. LOCAL ANESTHETICS.....YES NO

b. PENICILLIN OR OTHER ANTIBIOTICS.....YES NO

c. SULFA DRUGS.....YES NO

d. ASPIRIN.....YES NO

e. IODINE.....YES NO

f. CODEINE OR OTHER NARCOTICS.....YES NO

g. OTHER.....YES NO

7. HAVE YOU OR ANY FAMILY MEMBER EVER HAD TROUBLE WITH IV SEDATION OR GENERAL ANESTHESIA.....YES NO

8. DO YOU SMOKE.....YES NO

9. DO YOU, OR HAVE YOU HAD ANY OTHER CONDITION, DISEASE OR TREATMENT THAT YOU THINK I SHOULD KNOW ABOUT.....YES NO

10. WOMEN: ARE YOU PREGNANT?..... YES NO

ARE YOU NURSING?..... YES NO

ARE YOU TAKING BIRTH CONTROL PILLS.....YES NO

11. DO YOU HAVE ADVANCED DIRECTIVES YOU WOULD LIKE US TO BE AWARE OF?.....YES NO
IF YES PLEASE SPECIFY_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DOCTOR, OR ANY MEMBER OF THE STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ _____ _____

SIGNATURE OF PATIENT (PARENT OR GAURDIAN IF UNDER 18 YEARS) DATE DOCTORS' S INITIALS