

HEALTH QUESTIONNAIRE

Name: _____

Date: _____

Reason for referral: _____

HISTORY OF PAST ILLNESS - Have you had:

			<u>Number of Years</u>
High Blood Pressure	Yes	No	_____
Diabetes	Yes	No	_____
Prior Heart Disorder			_____
Angina (Chest Pain)	Yes	No	_____
Prior Heart Attack	Yes	No	_____
Rhythm Disturbance	Yes	No	_____
Prior Stroke	Yes	No	_____
Emphysema	Yes	No	_____
Any other serious illness			_____

SURGERIES

Year

_____	_____
_____	_____
_____	_____

MEDICATIONS YOU ARE PRESENTLY

DRUG ALLERGIES

_____	_____
_____	_____
_____	_____
_____	_____

Do you now, or have you ever smoked within the past 10 years? Yes No

Occupation (If retired, state prior occupation & year retired) : _____

FAMILY HISTORY: Is there a family history of (check all that applies)?

- Migraines
- Strokes or heart attacks before age 60
- Movement disorder (tremor, Parkinsonism)
- Other _____