IWH Wellness & Sport Evaluation Program
Health Questionnaire

Name _____ **Date** ____/____/20_____
(Last) (First) (Middle)

		Circle One	Notes
(1)	**Have you been under the care of a physician during the past 2 years?**	**Yes No**	
(2)	**Are you allergic to penicillin, any drugs, medicine, or latex?**	**Yes No**	
(3)	**Have you ever had excessive bleeding which required special treatment?**	**Yes No**	
(4)	**Women: Is there a chance you might be pregnant?**	**Yes No**	
(5)	**Women: Are you taking any birth control medication?**	**Yes No**	
(6)	**Have you had adverse reaction to local anesthetics?**	**Yes No**	
(7)	**Do you use recreational drugs?_____ If yes, what?_____**		
(8)	**Do you use tobacco? _____ If so, what form? _____**		
(9)	**Date of last medical exam _____**		

(10) Circle Yes to any of the following which you have had or have at present. Circle No to those that you have not had.

Yes	**No**	**High Blood Pressure**	**Yes**	**No**	**Unexplained Shortness of Breath**
Yes	**No**	**High Blood Cholesterol**	**Yes**	**No**	**Chronic Cough or Bronchitis**
Yes	**No**	**Chest Pain or Pressure (Angina)**	**Yes**	**No**	**Tuberculosis (TB)**
Yes	**No**	**Heart Disease or Attack**	**Yes**	**No**	**Emphysema**
Yes	**No**	**Heart Pacemaker**	**Yes**	**No**	**Asthma**
Yes	**No**	**Heart Failure**	**Yes**	**No**	**Hay Fever**
Yes	**No**	**Heart Surgery**	**Yes**	**No**	**Allergies or Hives**
Yes	**No**	**Fainting or Lightheadedness**	**Yes**	**No**	**Sinus Trouble**
Yes	**No**	**Artificial Heart Valve**	**Yes**	**No**	**Cancer**
Yes	**No**	**Congenital Heart Lesions**	**Yes**	**No**	**Leukemia or Lymphoma**
Yes	**No**	**Mitral Valve Prolapse**	**Yes**	**No**	**Radiation or Chemotherapy**
Yes	**No**	**Stroke**	**Yes**	**No**	**Anemia**
Yes	**No**	**Transient Ishemic Attack**	**Yes**	**No**	**Bruise Easily**
Yes	**No**	**Lupus**	**Yes**	**No**	**Bleeding Disorders**
Yes	**No**	**Rheumatic Fever**	**Yes**	**No**	**Sickle Cell Disease**
Yes	**No**	**Scarlet Fever**	**Yes**	**No**	**Alcoholism**
Yes	**No**	**Chronic Fatigue**	**Yes**	**No**	**Drug Addiction**
Yes	**No**	**Artificial Joints**	**Yes**	**No**	**Blood Transfusion**
Yes	**No**	**Kidney Dialysis**	**Yes**	**No**	**Liver Disease**
Yes	**No**	**Kidney Disease**	**Yes**	**No**	**Yellow Jaundice**
Yes	**No**	**Eating Disorder**	**Yes**	**No**	**Hepatitis**
Yes	**No**	**Rheumatoid Arthritis**	**Yes**	**No**	**AIDS / HIV Infection**
Yes	**No**	**Arthritis**	**Yes**	**No**	**Cold Sores / Fever Blisters**
Yes	**No**	**Chronic Head, Neck, or Back Pain**	**Yes**	**No**	**Psychiatric Treatment**
Yes	**No**	**Diabetes Requiring Insulin**	**Yes**	**No**	**Depression / Bipolar**
Yes	**No**	**Diabetes Not Requiring Insulin**	**Yes**	**No**	**Nervousness / Anxiety**
Yes	**No**	**Hypoglycemia**	**Yes**	**No**	**Dizzy Spells**
Yes	**No**	**Hyperthyroidism (High)**	**Yes**	**No**	**Epilepsy or Seizures**
Yes	**No**	**Hypothyroidism (Low)**	**Yes**	**No**	**Condition Requiring Cortisone Medicine**
Yes	**No**	**Ulcers**	**Yes**	**No**	**Glaucoma**
Yes	**No**	**Pulmonary Disease**	**Yes**	**No**	**Spine or Hip Fractures**

List all prescription medications that you are currently taking.

Medication/Dosage/Date Started/Reason _____

Medication/Dosage/Date Started/Reason _____

Medication/Dosage/Date Started/Reason _____

Medication/Dosage/Date Started/Reason _____

Medication/Dosage/Date Started/Reason _____

Medication/Dosage/Date Started/Reason _____

Please list all non-prescription medication or vitamins or nutritional supplements you are currently taking.

Name/Dosage/Date Started/Reason _____

Name/Dosage/Date Started/Reason _____

Name/Dosage/Date Started/Reason _____

Name/Dosage/Date Started/Reason _____

Name/Dosage/Date Started/Reason _____

Name/Dosage/Date Started/Reason _____

List all surgical procedures that you have had in the past.

Year _____ Type of Surgery/Reason _____

Year _____ Type of Surgery/Reason _____

Year _____ Type of Surgery/Reason _____

Year _____ Type of Surgery/Reason _____

List all hospitalizations of 24 hours or more for any reason.

Year _____ Reason for hospitalization _____

Year _____ Reason for hospitalization _____

Year _____ Reason for hospitalization _____

Year _____ Reason for hospitalization _____

Other Health Information

Please use this space to record any other personal health information that was not listed above.

_____

_____

"I Attest To The Fact That The Information Given Above Is Correct And I Consent To Receive Clinical Services."

_____

(Parent or Guardian must sign for patient under age 18.)

This section for office use only:

Comments:

_____

_____

_____

_____

_____