

**Rose T. Codini, MD / Poneh Rahimi, MD**  
**Health Questionnaire**

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**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Past Medical History:**

Have you ever had (or have) the following: (Please check if "yes", leave blank if "no")

Heart Problems	Yes ___ explain: _____	Pacemaker / Stent / Valve	Yes ___	
Infectious Diseases	Yes ___ explain: _____	High Blood Pressure	Yes ___	
Respiratory Problems	Yes ___ explain: _____	Prolonged Bleeding	Yes ___	
Cancer	Yes ___ explain: _____	Thyroid Disease	Yes ___	
Liver Disease	Yes ___	Diabetes	Yes ___	
	High Cholesterol	Yes ___	Anemia	Yes ___

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**Other Medical Conditions/ Surgeries:**

\_\_\_\_\_  
\_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

**History of Anesthesia (Reaction?):** \_\_\_\_\_

**Medications:** \_\_\_\_\_

(Prescription, over the counter, vitamins & herbs)

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**Patient Social History:**

Marital Status: Single: \_\_\_ Married: \_\_\_ Separated: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_  
Use of Alcohol: Never \_\_\_ Rarely: \_\_\_ Moderate: \_\_\_ Daily: \_\_\_  
Use of Tobacco: Never \_\_\_ Quit: \_\_\_ (If so, When? \_\_\_\_\_) Current packs/day: \_\_\_\_\_  
Use of Drugs: Never \_\_\_ Type/ Frequency: \_\_\_\_\_  
(Recreational)

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**Family Medical History:**

	<u>Age</u>	<u>Diseases/Health Problems</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers/ Sisters	_____	_____	_____
	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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