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.

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

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

This section for office use only:

Comments:

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