LOGAN HEALTH

Confidential Health Questionnaire

Please write legibly and complete this form to the best of your knowledge.

Patient Name: _____ DOB: _____ Age: _____

Weight: _____lbs Height: _____ Bra Size: _____ Unknown, N/A.

Primary Care Doctor: _____ Referring Provider: _____

What pharmacy do you use? _____

Name and dosage of any medications you currently taking (Including Vitamins, Herbals, Aspirin, Motrin, Ibuprofen, Fish Oil or Aleve):

_____ _____

_____ _____

_____ _____

Please list any known drug allergies and reactions (medications, tapes, latex or adhesives):

_____ _____

_____ _____

Have you been hospitalized for any reason in the past 3 months? ☐ Yes ☐ No

If Yes, Please Explain: _____

Please list all surgeries you've had, including the date: _____

_____ _____

_____ _____

Do you now have, or have you had in the past: please check (√) all that applies

- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Diabetes Mellitus or Pre-Diabetes
- ☐ Anemia
- ☐ Blood Disorder or Clotting Problems
- ☐ Easy Bruising
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ _____Cancer/Tumors
- ☐ Angina or Chest Pain
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Palpitations Irregular or rapid heartbeat
- ☐ Heart murmurs
- ☐ Asthma
- ☐ Varicose Veins
- ☐ Shortness of breath or wheezing
- ☐ Sleep apnea or use a CPAP machine
- ☐ High blood pressure
- ☐ Stomach or duodenal ulcer
- ☐ Stomach or intestinal bleeding
- ☐ Hepatitis
- ☐ Liver Problems
- ☐ Drug or Alcohol Dependency
- ☐ Frequent gum or nose bleeds
- ☐ AIDS or HIV positive
- ☐ Jaundice or liver disease
- ☐ Mood disturbance
- ☐ Depression
- ☐ Anxiety
- ☐ Eating Disorder
- ☐ Seizures
- ☐ Frequent heartburn or reflux
- ☐ Fainting or dizziness
- ☐ Nervous breakdowns
- ☐ Immune disorders or RA / Lupus
- ☐ Lung Disease
- ☐ Autoimmune disease
- ☐ COPD
- ☐ Glaucoma
- ☐ Kidney Problems
- ☐ Tuberculosis
- ☐ (DVT) Deep Vein Thrombosis
- ☐ (PE) Pulmonary Embolism

Other: _____

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LOGAN HEALTH

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partner

Number of pregnancies? ____ Number of children _____ ages: Son(s): _____Daughter(s): _____

Are you planning on having more children? ☐ Yes ☐ No

Is there any chance you are pregnant? ☐ Yes ☐ No

Has your weight been stable the last 6 months or more ☐ Yes ☐ No

Are you using a birth control method ☐Yes (which one) _____ ☐ No

At what age did you get your first menstruation? _____

Occupation: FT-PT: _____, Student, Self Employed-Retired-Disabled-Unemployed

Do you use tobacco products? ☐ Yes ☐ No ☐ Past

What type _____

How much _____

How many times a day _____

When did you stop _____

Do you use recreational drugs?

☐ Yes (Kind) _____ ☐ No

Do you drink alcohol? ☐Yes _____ ☐No

How many a week _____

Family Medical History: please check (V) all that applies

	Alive	Deceased	Cancer	Breast Cancer	Heart Disease	Genetic Condition	Diabetes	High Blood Pressure	Unknown	Healthy
Mother										
Father										
Brother(S)										
Sister(S)										
Son(S)										
Daughter(S)										
Maternal GM										
Maternal GF										
Paternal GM										
Paternal GF										

If (V), please explain: _____

_____

Does anyone including yourself or your family history have any blood clotting problems or any reaction to anesthesia? Is so, please explain: _____

Signature _____Date_____

Please turn this form into the front desk when completed.

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