



**ADULT HEALTH  
QUESTIONNAIRE**

ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

PAGE 1 OF 1

Patient Identification

Please fill out as completely as possible and bring with you on the day of your appointment

|                              |                      |
|------------------------------|----------------------|
| Name _____                   | Birthdate _____      |
| Home Telephone _____         | Work Telephone _____ |
| Referring Physician _____    | Phone _____          |
| Address _____                |                      |
| Primary Care Physician _____ | Phone _____          |
| Address _____                |                      |
| Pharmacy _____               | Phone _____          |

REASON FOR VISIT: \_\_\_\_\_

ALLERGIES (please include reaction) \_\_\_\_\_

Allergic to latex? \_\_\_\_\_ or lidocaine?: \_\_\_\_\_

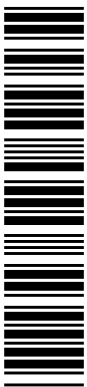
**ALL Current Medications and dosage: Please use separate page for medication list if necessary.**

|          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Are you currently taking Vitamin E, Anti-inflammatories, blood thinners, Aspirin? (please circle)

Do you take Antibiotics before dental work? \_\_\_ Yes \_\_\_ No  
Current lotions / creams / naturopathic medications: \_\_\_\_\_

| Health History: Current and past health problems  | Yes   | No    | Explain: |
|---|-------|-------|----------|
| General symptoms, such as:<br>fever, weight loss, chills, sweats, or<br>loss of appetite? | _____ | _____ | _____    |
| <b><u>SKIN DISEASE / DISORDERS</u></b>  | _____ | _____ | _____    |
| Childhood Eczema / Atopic Dermatitis  | _____ | _____ | _____    |
| Hayfever  | _____ | _____ | _____    |
| Psoriasis   | _____ | _____ | _____    |
| Skin Cancer (type?) (location)  | _____ | _____ | _____    |
| Scar/history of keloids   | _____ | _____ | _____    |
| <b><u>Eye problems / disorders</u></b>  | _____ | _____ | _____    |
| <b><u>Ears, Nose, or Throat problems/disorders</u></b>                                    | _____ | _____ | _____    |
| <b><u>Gastrointestinal disease/problems</u></b>   | _____ | _____ | _____    |
| <b><u>Respiratory disease / disorders</u></b>   | _____ | _____ | _____    |
| COPD/Emphysema  | _____ | _____ | _____    |
| Asthma  | _____ | _____ | _____    |
| Cancer  | _____ | _____ | _____    |
| <b><u>Renal (Kidney) Disease / problems</u></b>   | _____ | _____ | _____    |
| Genital / urinary problems  | _____ | _____ | _____    |
| Dialysis  | _____ | _____ | _____    |



OC4501



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|  | Yes   | No                      | Explain:        |
|--|-------|-------------------------|-----------------|
| <b>Cardiovascular</b>  |       |                         |                 |
| Angina / Heart Attack  | _____ | _____                   | _____           |
| Valve Disease/ Murmur  | _____ | _____                   | _____           |
| Prosthetic Valve   | _____ | _____                   | _____           |
| Rheumatic Fever  | _____ | _____                   | _____           |
| Hypertension   | _____ | _____                   | _____           |
| Arrhythmia   | _____ | _____                   | _____           |
| Pacemaker  | _____ | _____                   | _____           |
| Peripheral Vascular Disease  | _____ | _____                   | _____           |
| <b>Hepatic (Liver) Disease/Problems</b>  |       |                         |                 |
| Hepatitis / Jaundice   | _____ | _____                   | _____           |
| Decreased function   | _____ | _____                   | _____           |
| <b>Cancer (other than skin cancer)</b>   |       |                         |                 |
| <b>Muscle or Bone Disorders/Disease</b>  |       |                         |                 |
| Artificial Joint / Date of Surgery   | _____ | _____                   | _____           |
| Arthritis(type?)   | _____ | _____                   | _____           |
| <b>Neurological Disorders/problems</b>   |       |                         |                 |
| Seizure  | _____ | _____                   | _____           |
| Pre-existing nerve damage at site to be treated?   | _____ | _____                   | _____           |
| <b>Autoimmune disease</b><br>(scleroderma, rheumatoid arthritis, lupus, dermatomyositis, or other) |       |                         |                 |
| <b>Transplant</b>  |       |                         |                 |
| _____  | _____ | Type: _____ Year: _____ |                 |
| <b>Endocrine disease (type?)</b>   |       |                         |                 |
| Diabetes   | _____ | _____                   | _____           |
| Thyroid  | _____ | _____                   | _____           |
| <b>Psychiatric Disease/disorder</b>  |       |                         |                 |
| <b>HIV / AIDS</b>  |       |                         |                 |
| Are you currently pregnant / breastfeeding?  |       |                         |                 |
| Last menstrual period, if applicable   |       |                         |                 |
| <b>Social History:</b>   |       |                         |                 |
| Occupation: Past and Present   |       |                         |                 |
| Please list materials you are in contact with  |       |                         |                 |
| Alcohol use  | _____ | _____                   | _____ how often |
| Tobacco use  | _____ | _____                   | _____ pk/day    |
| Live alone?  |       |                         |                 |
| Any other health problems/concerns   |       |                         |                 |
| Significant family medical history/skin cancer   |       |                         |                 |

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_