medica

HEALTH QUESTIONNAIRE

Question	Yes	No	Details
1. Do you suffer from any heart disease? (Infarction, heart failure, pacemaker, catheterization)			State which disease and date of any procedure
2. Do you suffer from high blood pressure?			
3. Do you suffer from diabetes?			
4. Do you suffer from a pulmonary disease? (Asthma, bronchitis)			
5. Do you suffer from a disease of the digestive system? (Heartburn, reflux)			
6. Do you suffer from a kidney disease? (Renal failure, stones, a chronic disease)			
7. Do you suffer from a disease of the nervous system? (Convulsions)			
8. Do you suffer from muscle disease?			
9. Do you have disorders of the blood coagulation mechanism? (Haemorrhaging, hematomas)			
10. Are you receiving anti-coagulation medications? (Blood dilution)			State which medications.
11. Are you pregnant?			
12. Are you being treated with psychiatric medications?			State which medications.
13. Are you a carrier of AIDS, Hepatitis B, C, cirrhosis?			State which
14. Do you have any other diseases not noted on this page?			State which
15. Do you use drugs?			
16. Do you regularly drink alcohol?			How many glasses per day
17. Have you suffered from flu, a cold over the past weeks?			
18. Are you allergic to medications?			
19. Are you allergic to latex?			
20. Do you smoke?			
21. Can you climb to the second floor of stairs?			
22. Do you have breaks in your sleep? (Snoring)			
23. Surgeries in the past?			
24. Complications of anaesthesia in previous surgeries?			
25. Previous hospitalizations?			
26. Dental condition: Do you have crowns/dentures/implants?			
27. Do you take medications on a regular basis?			State which: _____ _____ _____ _____

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I hereby declare that all the answers that I have given are correct.

Date:_____ Patient/s signature:_____

Habarzel 28, Ramat Hahayal, Tel Aviv, Tel: *2147 רחוב הברזל 28 רמת החייל, תל–אביב, טלפון: