artemedica
1002 Mendocino Avenue
Santa Rosa, CA 95401
(707) 577-8292

HEALTH AND WELLNESS QUESTIONNAIRE

Name: _____ Date _____

Email: _____ Phone #: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

Allergies: _____ Reaction: _____

Medications: _____

Please circle Yes or No for the following questions. If your response is Yes, please describe.

MEDICAL INFORMATION

Y N Weight loss or gain: ____ lbs _____
Y N Diabetes _____HgA1c_____
Y N Wound healing problems: difficulty healing wounds, keloids, hypertrophic scars; locations_____
Y N Cancer of any sort _____
Y N Chest pain, palpitations, heart devices, Heart disease or any heart problems
_____
Y N HIGH BLOOD PRESSURE _____
Y N Thyroid, endocrine or hormonal problems _____
Y N Difficulty swallowing _____
Y N Eye problems, infections, or injuries _____
Y N Nasal problems, difficulty breathing, nose injuries _____
Y N Lung problems, pneumonia, TB, asthma, shortness of breath, use of an inhaler _____
Y N Kidney, bladder, or urinary problems _____
Y N Epilepsy, convulsions, seizures _____
Y N Migraines/TMJ_____ _____
Y N HIV or AIDS _____If YES, what is your viral load? _____
Y N Herpes, cold sores, shingles _____
Y N ANY infections requiring hospitalization (explain) _____
Y N ANY abnormal lab test or X-ray (describe) _____
Y N EVER hospitalized and why _____
Y N DATE of last physical exam, by whom _____

artemedica
1002 Mendocino Avenue
Santa Rosa, CA 95401
(707) 577-8292

HEALTH AND WELLNESS QUESTIONNAIRE

BLOOD CLOTTING INFORMATION

Y N History of DVT (deep venous clots), PE (pulmonary embolus), or phlebitis (vein infections)
Y N Difficulty blood clotting or easy bruising or easy bleeding _____

SURGICAL HISTORY

Y N List all surgeries you have had _____
Y N Have you ever had LASIK or other eye surgery _____
Y N Difficulty ***or nausea*** with local or general anesthesia _____

FAMILY HISTORY

Y N Any cancer in your family? What kind and who? _____
Y N Any bleeding or blood clots in your family? What kind and who? _____
Y N Any history of difficulty with general anesthesia in your family? What kind and who?
_____

PERSONAL HISTORY

Y N Smoking (ever) how much, when_____
Y N Recreational drugs _____
Y N Alcohol, how much _____
Y N If you undergo surgery, do you have a caretaker? _____

MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING

Y N Prescription medications _____
Y N Vitamins _____
Y N Herbal supplements including herbal teas_____
Y N Non-prescription or over-the-counter medications _____
Y N Recreational drugs, steroids _____

PHARMACY : _____ **IN** _____**STREET** _____

Name: _____ **DATE:** _____