

## Surgery of London

### Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Other Physician: \_\_\_\_\_

Why are you here to see the doctor?

\_\_\_\_\_

**Medications:**


**Allergies:** \_\_\_\_\_

**Past Medical Problems:** (please check if you have had any of the following)

- |                                       |             |  |             |  |             |  |
|---------------------------------------|-------------|--|-------------|--|-------------|--|
| <input type="checkbox"/> Heart Attack | <u>ICD9</u> | <input type="checkbox"/> High Blood Pressure | <u>ICD9</u> | <input type="checkbox"/> Thyroid Disease   | <u>ICD9</u> | <input type="checkbox"/> Reaction to dyes/ shellfish |
| <input type="checkbox"/> Angina       | 414.00      | <input type="checkbox"/> Diabetes            | 401.9       | <input type="checkbox"/> Bleeding Disorder | 244.9       | <input type="checkbox"/> Claustrophobic              |
| <input type="checkbox"/> Arrhythmia   | 413.9       | <input type="checkbox"/> Anemia              | 250.00      | <input type="checkbox"/> Stroke            | 286.9       | <input type="checkbox"/> Metal Implants              |
| <input type="checkbox"/> Lung Disease | 427.9       | <input type="checkbox"/> Kidney Failure      | 285.90      | <input type="checkbox"/> Seizures          | 436         | <input type="checkbox"/> Pacemaker Implant           |
| <input type="checkbox"/> Asthma       | 496         | <input type="checkbox"/> Acid Reflux         | 586         | <input type="checkbox"/> Cancer            | 780.39      | <input type="checkbox"/> Defibrillator Implant       |
| <input type="checkbox"/> Sleep Apnea  | 493.90      | <input type="checkbox"/> High Cholesterol    | 530.81      | <input type="checkbox"/> Other             |             | <input type="checkbox"/> Latex Allergy               |
|                                       | 780.57      |  | 272.0       |  |             |  |

If you checked any of the above, please briefly explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Surgeries:**

\_\_\_\_\_

\_\_\_\_\_

**Family Medical History:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Heart Attack       | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Colon Cancer  | <input type="checkbox"/> Other Cancer _____ |   |  |

\_\_\_\_\_  
Physician Initial's

\_\_\_\_\_  
Date