Health Questionnaire

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

	YES	NO		YES	NO
Problems with Anesthesia			Tuberculosis		
High Fevers after Anesthesia			Bronchitis, Asthma, Emphysema		
Loose Teeth / Dentures			Shortness of Breath		
Glasses / Contact Lenses			Any problems with Sleep Apnea		
Aneurysms			Do you Smoke / Ever smoked		
Seizures			Oxygen Dependent		
Black Outs (syncope)			If YES, how much? _____		
Stroke			☐ Day & Night ☐ At night ONLY		
High Blood Pressure (even if controlled)			Hiatal Hernia / Nausea / Heartburn		
HEART PROBLEMS:			Hepatitis / Jaundice		
Heart Attack			Family history of:		
Chest Pain			colon / esophageal / stomach Cancer		
Irregular Heartbeat / Palpitations			Diabetes		
Heart Failure			Thyroid Trouble		
Heart Surgery			Blood Clotting problems		
Heart Valve Problems			History of Bleeding / Anemia		
Heart Stents? If yes, Date:			Sickle Cell Disease		
Do you have a Pacemaker			Any Neck or Back problem		
Pacemaker with Defibrillator			Are you pregnant now		
Brand:			Kidney Trouble		
Cardiac Cath in the last 18 months:			Are you on Dialysis?		
Test completed @:			Autoimmune Disesase: Lupus or		
Echocardiogram in last 18 months:			Rheumatoid Arthritis or other:		
(ultrasound x-ray of the heart)			History of alcohol or drug abuse		
Test completed @:			History of Anxiety / Depression		
Stress test in last 18 months:			Other Problems not mentioned?		
Test completed @:			(please explain)		
Height: _____ Weight: _____					

Allergies:

Current Medications:

Prior Surgeries:

Pharmacy: Primary Care Physician:

Emergency Contact Name: Phone: Relationship:

Current Insurance: Primary: Secondary:

I certify that the information above is true and accurate, that I have coverage with the above insurance(s) and assign directly to Gastroenterology & Nutrition of Central Florida all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the disclosure of my health care information in order to obtain payment of insurance benefit information from the above named insurance company (ies).

I hereby authorize and consent for medical treatment provided by Gastroenterology & Nutrition of Central Florida. I have read and received a copy of the Notice of Privacy Practice for Gastroenterology & Nutrition of Central FL, LLC.

PRINT Patient Name **Email Address**

Patient Signature **Date**