HEALTH QUESTIONNAIRE

MALVERN SLEEP CLINIC
1371 Neilson Road, Suite 306, Scarborough, ON M1B 4Z8
Phone: (416) 282-9119 FAX: (416) 282-4141

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

NAME: ____ DATE OF BIRTH: ____/____/____ AGE: ___ SEX: M / F
Last First Middle Day Month Year

Family/Primary doctor: DR. ____

PAST MEDICAL PROBLEMS (CIRCLE): heart disease / high blood pressure / asthma / allergies / diabetes / high cholesterol / arthritis / acid reflux / kidney disease / epilepsy / hemophilia / other: ____________________

PAST SURGERIES: ____

FAMILY HISTORY: cancer / heart disease / bleeding disorder / arthritis / other: ____________________

CURRENT MEDICATIONS: (Please fill in the list below or if no medications check here: ___ NO MEDICATIONS)

NAME OF MEDICATION	DOSAGE/STRENGTH	TIMES PER DAY

DO YOU HAVE ANY MEDICATION ALLERGIES? yes/no List allergies: ____________________
OTHER ALLERGIES? Latex? yes/no Anesthetics? yes/no Iodine? yes/no Foods? Yes/no ____________

HISTORY OF (NOW OR IN THE PAST): Smoking: yes/no Alcohol: yes/no Drug use: yes/no
Artificial joints/implants: yes/no Heart valve/mitral valve problem: yes/no HIV/AIDS/Hepatitis/other: yes/no
FEMALES: Are you currently pregnant or trying to become pregnant? yes/no

Acknowledgement: I give permission for medical treatment and release of health information to my family doctor, referring doctor, insurance company, or as needed for continued medical care. I will be responsible for keeping my follow-up appointments for continued medical care, and follow-up to go over results of blood tests, X-rays, etc. as recommended by Dr. B. Marcarian.

____________________ SIGNATURE (PATIENT/GUARDIAN)
____________________ PRINT NAME
____/____/____ DATE: (DAY/MONTH/YEAR)

(Reviewed by Dr. Berge Marcarian: ____________________)

--OFFICE USE --