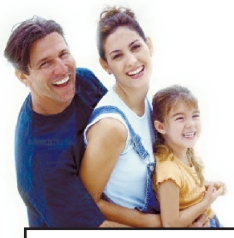

HEALTH QUESTIONNAIRE

HAVE YOU HAD: (PLEASE "X" EACH BOX IF THE ANSWER IS "YES" ; LEAVE BLANK IF THE ANSWER IS "NO")

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Adenoids removed
- ☐ A.I.D.S.
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Ulcer
- ☐ Chronic fatigue
- ☐ Radiation treatments
- ☐ Tonsils removed
- ☐ Gallbladder problems
- ☐ Circulatory problems
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Excessive bleeding
- ☐ Anemia
- ☐ Alcoholism
- ☐ Scarlet fever
- ☐ Cerebral palsy
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Kidney problems
- ☐ Chronic sinus problems
- ☐ Chronic ear problems
- ☐ Shortness Of breath
- ☐ Venereal disease/Herpes
- ☐ Arthritis
- ☐ Gout
- ☐ Malignancies
- ☐ Asthma
- ☐ H.T.L.V.
- ☐ Allergies/Hay fever
- ☐ Liver problems

Other health complications not listed above_____

List any types of surgeries you have had and the approximate date on which they occurred:_____

_____

List any type of fractures or bone injuries which you have had:_____

List any known allergies:_____

List all medications you are currently taking: _____

_____

List any other medical conditions you feel the doctor should be aware of :_____

_____

Have you ever been hospitalized? ☐ No ☐ Yes If yes, please explain _____

_____

(Women only) Are you pregnant? ☐ No ☐ Yes Nursing? ☐ No ☐ Yes
Taking birth control pills? ☐ No ☐ Yes

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, and I understand that providing incorrect information can be dangerous to my health. I authorize Rapha Clinic and its staff to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such health care to third party payers and/or health practitioners.

X _____ _____/_____/_____

Signature of patient (or parent if a minor) Date