Cholinesterase Questionnaire

Employee to bring completed form to visit.

Name: _____ **Date:** _____
Address:_____ **Phone:** _____
Date of Birth: _____ **Social Security Number:** _____
Employer: _____**Job Title:** _____

Have you had or do you presently have any of the following:

	Yes	No		Yes	No
Severe headaches			Chest pain		
Loss of consciousness			Heart problems		
Epilepsy, seizures			Skin problems		
Dizziness, fainting spells			Stomach problems		
Nervous disorders			Nausea/vomiting at present		
Numbness,tingling in arms, legs			Ulcers, heartburn		
Shortness of breath			Colitis		
Chronic cough			Black/bloody bowel movements		
Emphysema, COPD, chronic bronchitis			Hepatitis		
Asthma			Diabetes		
Tuberculosis			Kidney problems		
Asbestosis, silicosis			Glaucoma		
High blood pressure			Myasthenia gravis		

Please explain all Yes answers:

_____
_____
_____

Have you ever had surgery? No ____ Yes ____ If yes, for what? _____

_____

Are you currently under a doctor's care? No _____ Yes _____ If yes, for what? _____

Name of Doctor: _____ Do you smoke? No ____ Yes ____ If yes, how much per day?_____

Any allergies? _____

Are you taking any medications or supplements? No ____ Yes ____ If yes, what and how often? _____

_____

Do you take Tylenol (acetaminophen)? No ____ Yes ____ If yes, how much, how often? _____

How many alcohol drinks average per week: Beer ____ Wine ____ Hard liquor ____ None ____

Do you use recreational drugs? No ____ Yes ____ If yes, what and how often? _____

I hereby certify that all of the above answers are true to the best of my knowledge.

Signed: _____ **Date:** _____

Medical provider comments:

_____
_____
_____
_____