Patient Health History

NAME: _____ DOB: _____ AGE: _____ DATE: _____

List ALL prior surgeries and dates: _____

_____

_____

Current Medications, including dosages: _____

_____

_____

Vitamins and Herbs: _____

_____

Drug Allergies: _____

Explain: _____

Describe any complication with anesthesia: _____

Did you ever have post op nausea and vomiting?_____ Motion sickness? Y or N

Yes /No

Y N Were you told it was difficult to insert a breathing tube? Height_____ Weight_____

Y N Have any of your blood relatives had problems with anesthesia? (e.g. high fevers, difficulty awakening)

Y N Are you allergic to iodine? Describe reaction: _____

Y N Are you allergic to latex? Describe reaction: _____

Y N Do you have problems with your heart or blood vessels?

Y N Have you had a previous heart attack? Date:_____

Y N Chest pain / angina?

Y N Skipped heartbeats or palpitations? Mitral valve prolapse?

Y N Heart failure, pacemaker or implanted cardiac defibrillator (ICD)?

Y N Have you had an increase in severity or frequency of your heart symptoms over the past year?

Y N Have you been hospitalized for any of these heart problems? When? _____ Results? _____

Y N Have you had a recent stress test or other special heart test? When? _____ Results? _____

Y N Have you ever been told you have high blood pressure? For how long?_____

Y N Have you ever had a stroke or partial stroke? When? _____ Results? _____

Y N Do you have any problems with your lungs?

Y N Shortness of breath or cough productive of sputum?

Y N Emphysema/bronchitis/asthma/sleep apnea? Any wheezing this week? _____ Inhaler _____

Y N Do you have a CPAP machine?

Y N Have you ever been hospitalized for emphysema or asthma?

Y N Have you had fever, chills, cold, or flu within the past week?

Y N Do you have diabetes? For how long?_____

Y N Do you have epilepsy or seizures? For how long? _____

(Circle all that apply) Problems with:

Liver (Cirrhosis, hepatitis, jaundice, alcoholism) Dates: _____

Kidneys (stones, infection, failure, dialysis) Dates: _____

Blood (anemia, leukemia, sickle cell) Dates: _____

Thyroid gland (over or under active) Dates: _____

(Circle all that apply) frequent heartburn, indigestion, acid reflux from your stomach, stomach ulcer, or hiatal hernia

What medications do you take for these problems? _____

NAME: _____ DOB: _____ AGE: _____ DATE: _____

Yes /No

Y N Have you had a blood transfusion? When? _____
Y N Could you have any blood infections such as HIV or Hepatitis B/C?
Y N Have you ever had a serious bleeding or clotting disorder (e.g. hemophilia, bruising)?
Explain: _____
Y N Do you have false teeth or oral jewelry?
Y N Do you have neck or back problems (e.g. arthritis, herniated disc)? Surgery: _____
Y N Have you had any eye surgery/laser? Dates: _____
Y N Have you had glaucoma, detached retna, other? Dates: _____
Y N Have you ever been diagnosed with cancer (e.g. breast, skin, lung, colon)? Dates: _____
Y N Have you ever used recreational drugs? What? _____# years? _____ Last used? _____
Y N Past/Present cigarette use? # per day _____ # years _____ Date stopped _____
Other Tobacco use? _____

Alcohol Use: Weekly _____ Daily _____ Never _____

Are you under any anxiety/emotional distress/depression/nervous breakdown? YES NO
If yes, please explain_____

Menses: Tubal _____ Hysterectomy _____ Menopause #yrs _____ LMP _____

Describe other health concerns/problems: _____
_____

Family members with the above diseases: _____
_____

Have you ever used Accutane? YES NO When? _____
Have you ever used diet pills? YES NO What? _____ When? _____
Have you ever been treated for a skin staph infection? YES NO
If yes, please explain_____
Take Aspirin or aspirin-containing products regularly? YES NO
Form "keloid" (thick, irregular) scars? YES NO
Have you had any recent weight changes? YES NO
If yes, please explain_____