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? _____

Yes /No

- ☐ ☐ Were you told it was difficult to insert a breathing tube? Height_____ Weight_____
- ☐ ☐ Have any of your blood relatives had problems with anesthesia? (e.g. high fevers, difficulty awakening)
- ☐ ☐ Are you allergic to iodine? Describe reaction: _____
- ☐ ☐ Are you allergic to latex? Describe reaction: _____
- ☐ ☐ Do you have problems with your heart or blood vessels?
- ☐ ☐ Have you had a previous heart attack? Date:_____
- ☐ ☐ Chest pain / angina?
- ☐ ☐ Skipped heartbeats or palpitations? Mitral valve prolapse?
- ☐ ☐ Heart failure, pacemaker or implanted cardiac defibrillator (ICD)?
- ☐ ☐ Have you had an increase in severity or frequency of your heart symptoms over the past year?
- ☐ ☐ Have you been hospitalized for any of these heart problems? When? _____ Results? _____
- ☐ ☐ Have you had a recent stress test or other special heart test? When? _____ Results? _____
- ☐ ☐ Have you ever been told you have high blood pressure? For how long?_____
- ☐ ☐ Have you ever had a stroke or partial stroke? When? _____ Results? _____
- ☐ ☐ Do you have any problems with your lungs?
- ☐ ☐ Shortness of breath or cough productive of sputum?
- ☐ ☐ Emphysema/bronchitis/asthma/sleep apnea? Any wheezing this week? _____ Inhaler _____
- ☐ ☐ Do you have a CPAP machine?
- ☐ ☐ Have you ever been hospitalized for emphysema or asthma?
- ☐ ☐ Have you had fever, chills, cold, or flu within the past week?
- ☐ ☐ Do you have diabetes? For how long?_____
- ☐ ☐ Do you have epilepsy or seizures? For how long? _____

Problems with:

Yes/No

- ☐ ☐ Liver (Cirrhosis, hepatitis, jaundice, alcoholism) Explain:

  _____
- ☐ ☐ Kidneys (stones, infection, failure, dialysis) Explain:

  _____
- ☐ ☐ Blood (anemia, leukemia, sickle cell) Explain:

  _____
- ☐ ☐ Thyroid gland (over or under active) Explain:

  _____

Problems with:

Yes/No

☐ ☐ Frequent heartburn. Medications: _____
☐ ☐ Indigestion. Medications: _____
☐ ☐ Acid reflux. Medications: _____
☐ ☐ Stomach ulcers. Medications: _____
☐ ☐ Hiatal hernia. Medications: _____

Yes /No

☐ ☐ Have you had a blood transfusion? When? _____
☐ ☐ Could you have any blood infections such as HIV or Hepatitis B/C? Explain: _____
☐ ☐ Have you ever had a serious bleeding or clotting disorder (e.g. hemophilia, bruising)?
Explain: _____
☐ ☐ Do you have neck or back problems (e.g. arthritis, herniated disc)? Surgery: _____
☐ ☐ Have you had any eye surgery/laser? Dates: _____
☐ ☐ Have you had glaucoma, detached retna, other? Dates: _____
☐ ☐ Have you ever been diagnosed with cancer (e.g. breast, skin, lung, colon)? Dates: _____
☐ ☐ Have you ever used recreational drugs? What? _____
years? _____ Last used? _____
☐ ☐ 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