

HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)

No Yes **If yes, please list below. If you run out of room, use the back of this sheet for additional information.**

(TAB 1) PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY)

Name, dose and how often	Problem being treated	Date of Prescription	Prescribing Doctor

(TAB 2) Are you allergic to ANY medication? No Yes **If yes, please list below.**

Name of Medication	Type of Reaction

(TAB 3) NON MEDICATION ALLERGIES

Are you allergic to seafood? No Yes **If yes, what reaction do you have?** _____

Are you allergic to any non-medical things such as latex, tape, metal? No Yes latex tape metal

(TAB 4) PAST HEALTH Have you ever been DIAGNOSED with any major health problem? Including but not limited to:

Cancer: bone breast lung lymphoma
 multiple myeloma prostate

Heart and Blood Vessels:

Cerebral Vascular Accident (stroke) No Yes **If yes, when** _____

Heart disease No Yes **If yes, when** _____

High Blood pressure No Yes **If yes, when** _____

Thrombophlebitis No Yes **If yes, when** _____

Lungs and Respiratory:

Asthma No Yes **If yes, when** _____

COPD No Yes **If yes, when** _____

Emphysema No Yes **If yes, when** _____

Stomach and Digestive:

Hepatitis (type _____) No Yes **If yes, when** _____

Stomach ulcer No Yes **If yes, when** _____

Kidney and Gender Problems:

Are you pregnant? No Yes

Prostrate enlargement No Yes **If yes, when** _____

Renal failure No Yes **If yes, when** _____

Renal insufficiency No Yes **If yes, when** _____

Mental & Emotional:

Alcohol or drug treatment No Yes **If yes, when** _____

Anxiety, chronic No Yes **If yes, when** _____

Depression No Yes **If yes, when** _____

Glands, Hormones, and Sugar Control:

Diabetes (type _____) No Yes **If yes, when** _____

Blood & Lymph Node problems:

Hemophilia No Yes **If yes, when** _____

Sickle cell anemia No Yes **If yes, when** _____

Allergies, Immune & Infectious Problems:

AIDS No Yes **If yes, when** _____

HIV positive No Yes **If yes, when** _____

(TAB 5) SURGERIES AND HOSPITALIZATIONS

Have had problems with anesthesia (being numbed or put to sleep)?

high fever trouble with intubation (placement of breathing tube)

Have you ever had surgery? No Yes

If yes, list types and when they were done. _____

(TAB 8) FAMILY HISTORY

- Family history not known
- No family history of significant or pertinent health problems

Specific Anesthesia Problem Mother Father Brother Sister

Heart and Blood Vessels:

Heart Disease Mother Father Brother Sister

Bones, Joints and Muscles:

Arthritis Mother Father Brother Sister

Osteoporosis Mother Father Brother Sister

Glands, Hormones and Sugar Control problems:

Diabetes Mother Father Brother Sister

Blood & Lymph Node problems:

Bleeding/clotting problem Mother Father Brother Sister

(TAB 9) SOCIAL HISTORY

What is your current occupation? _____

Have you ever used tobacco in any form? No Yes

Have you ever used alcohol in any form? No Yes

Are you or have you been dependent or addicted to any drug? No Yes

marijuana cocaine morphine heroin diazepam (valium) soma

Do you use drugs recreationally? No Yes

marijuana cocaine morphine heroin diazepam (valium) soma

Which is your dominant hand? Right Left Ambidextrous

(TAB 10) REVIEW OF SYSTEMS List any problems you have or have had recently in the following areas.

Circle the symptom you are having

General Constitutional (Night sweats) No Yes

Head & Face (drooping on one side of face) No Yes

Ear, nose, mouth, throat, neck (Ringing in ears) No Yes

Nose & Sinus (frequent nosebleeds)..... No Yes

Neck (swollen glands)..... No Yes

Heart and Blood Vessels (Blacking out or fainting, Chest pain,) No Yes

Lungs and respiratory system (Shortness of breath or difficulty breathing)..... No Yes

Stomach and digestive system (Blood in stool, Gastrointestinal bleeding) No Yes

Kidneys or bladder or Sexual health (Unable to control bladder or loose urine with straining, Increased frequency) No Yes

Bones, Joints, or Muscles (Difficulty doing your usual activities, Painful joints, Swelling of joints, Weakness)..... No Yes

Brain and nervous system (Seizures)..... No Yes

Blood and lymph nodes (Bleeds excessively after injury, Bruise easily)..... No Yes

Allergies, infections, immune system (Unusual infections)..... No Yes