PATIENT HEALTH HISTORY

Name:_____ **Age:** _____

Primary Physician:_____

Specialty Physician:_____

Dentist:_____

1. Have you had any surgical procedures? NO YES

Please list: _____

_____

2. Have you been under the care of a medical doctor, or naturopathic doctor during the last two years? NO YES

3. Are you currently taking any medications? (including herbals and supplements) NO YES

Please list: _____

_____

4. Are you allergic to or made sick by any medication, latex, or foods? NO YES

5. Are you able to take NSAIDS (Aspirin/ Ibuprofen/ Advil/ Motrin/ Naproxen)? NO YES

6. Have you ever been put to sleep, had general anesthetic or sedation? NO YES

7. Have you or any family member had a serious reaction or fever from an anesthetic? NO YES

8. Have you ever had any excessive bleeding requiring special treatment? NO YES

9. Do you smoke/ vape/ marijuana? _____ Packs per day/ frequency? _____ How long? _____

10. Do you use snuff/ chew/ pouches? _____ How long? _____

11. Do you drink beer, wine or liquor? _____ How often? _____

12. **Circle any of the following conditions or ailments which you have had or have at the present:**

Asthma
Bronchitis
Pneumonia
Emphysema
Breathing Problems
Cough
Tuberculosis
Hay Fever
Shortness of Breath
Heart Disease
Heart Attack
Heart Failure
Angina (Chest Pain)
Rheumatic Fever
Mitral Valve Prolapse
Heart Murmur
Artificial Heart Valve
Irregular Beats
Palpitation
Pacemaker
High Blood Pressure
High Cholesterol
Kidney Trouble
Bladder Infection
Stomach Problems
Ulcers
GERD/Acid Reflux
Glaucoma
Thyroid Disease
Diabetes
Growth Disturbance
Sarcoidosis
Cortisone Injection
Steroid Therapy
Hormone Replacement
Lupus
Arthritis
Rheumatism
Artificial Joint (Replacement)
Osteoporosis
Stroke
Epilepsy or Seizures
Nervous or Anxious Feeling
Parkinsons
Alzheimer's / Dementia
Fainting or Dizzy Spells
Poor Circulation
Bleeding Problems
Bruise Easily
Anemia
Sickle Cell Disease
Hemophilia
Blood Disease

Depression	**Difficulty Sleeping**	**Blood Transfusion**
Mental Illness	**Sleep Apnea**	**Auto-Immune Disease**
Psychiatric Treatment	**Hepatitis (Infectious or Serum)**	**Sexually Transmitted Disease**
Counseling	**Liver Disease**	**Cold Sore/Fever Blister**
Drug or Alcohol Abuse	**Yellow Jaundice**	

13. When you walk up stairs or take a walk, do you ever have to stop because of chest pain, shortness of breath, or because you are very tired? NO YES

14. Do you have a strong gag reflex or difficulty swallowing pills? NO YES

15. Do you have swelling during the day? NO YES

16. Do you ever wake up from sleep short of breath? NO YES

17. Have you lost or gained more than 10 pounds in the past year? NO YES

18. Are you on a special diet? NO YES

19. Have you ever had a cancer or a tumor? NO YES

20. Do you have any disease, condition, problem or concern not listed? NO YES

21. Women Only: Are you pregnant, or do you anticipate becoming pregnant? ..... NO YES

Do you have children? Number: _____ ..... NO YES

Were there any delivery complications ..... NO YES

Are you taking birth control pills? ..... NO YES

I understand that taking antibiotics may alter the effectiveness of my oral contraceptives NO YES

Would you like to consult your physician for a pregnancy test before any surgery? NO YES

To the best of my knowledge, all of the preceding answers are true, complete and correct. If I ever have any change in my health or medicines, I will inform the doctor at the next appointment. I request and consent to an examination, records and photographs advisable in the doctor's opinion which will be used only for patient care, education, research or consultation with other health professionals. I understand informed consent will be given prior to any surgical procedure.

_____ _____ _____

SIGNATURE OF PATIENT OR GUARDIAN *Reviewed by* ***DATE***

STAFF ONLY

ASA Medical Problems Medications Allergies

I.

II.

III.

IV.

_____
WT
_____
HT
_____
BP
_____
PULSE

UPDATED _____

ASA Medical Problems Medications Allergies

I.

II.

III.

IV.

_____
WT
_____
HT
_____
BP
_____
PULSE