

PATIENT HEALTH HISTORY

Name: _____ Age: _____

Primary Physician: _____

Specialty Physician: _____

Dentist: _____

Preferred Pharmacy: _____



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:

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

Depression
Mental Illness
Psychiatric Treatment
Counseling
Drug or Alcohol Abuse

Difficulty Sleeping
Sleep Apnea
Hepatitis (Infectious or Serum)
Liver Disease
Yellow Jaundice

Blood Transfusion
Auto-Immune Disease
Sexually Transmitted Disease
Cold Sore/Fever Blister

- | | | |
|---|----|-----|
| 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.				WT
II.				HT
III.				BP
IV.				PULSE

UPDATED _____

ASA	Medical Problems	Medications	Allergies	_____
I.				WT
II.				HT
III.				BP
IV.				PULSE