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PATIENT NAME_____ **DATE OF BIRTH** _____

HEALTH PROBLEMS AND MEDICATIONS HAVE AN IMPORTANT EFFECT ON THE CARE YOU WILL BE RECEIVING. PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE. ALL INFORMATION THAT YOU PROVIDE US WITH WILL REMAIN CONFIDENTIAL.

HEALTH HISTORY

ARE YOU IN GOOD HEALTH?_____HEIGHT_____WEIGHT_____
HAVE THERE BEEN ANY RECENT CHANGES IN YOUR GENERAL HEALTH?_____
ARE YOU UNDER THE CARE OF A PHYSICIAN_____ DATE OF LAST VISIT_____
IF SO, WHAT ARE YOU BEING TREATED FOR_____
HAVE YOU HAD ANY ILLNESS, OPERATION, OR BEEN HOSPITALIZED IN THE PAST 5 YEARS: _____
_____
HAVE YOU EVER HAD A REACTION TO GENERAL ANESTHESIA?_____
HAVE YOU EVER HAD TROUBLE GETTING NUMB?_____
DO YOU SMOKE_____ HOW MUCH _____
DO YOU DRINK ALCOHOL?_____ _____ HOW MUCH_____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?	**YES**	**NO**	**NOTES**	**HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?**	**YES**	**NO**	**NOTES**
ASTHMA				CONVULSIONS/ EPILEPSY			
BRONCHITIS OR CHRONIC COUGHING				KIDNEY TROUBLE			
EMPHYSEMA				RENAL DIALYSIS			
DIFFICULTY BREATHING				INFECTIOUS MONONUCLEOSIS			
OTHER LUNG DISEASE				GALL BLADDER TROUBLE			
HEART MURMUR				ARTHRITIS			
RHEUMATIC FEVER				OTHER JOINT DISEASES			
DAMAGED HEART VALVE/MITRAL VALVE PROLAPSE				ARTIFICIAL JOINTS			
HEART RHYTHM DISORDER				STOMACH ULCERS			
CHEST PAIN WITH STRESS OR PHYSICAL EXERTION				SEXUALLY TRANSMITTED DISEASES			
HEART SURGERY				AIDS OR HIV INFECTION			
HEART ATTACK				IMMUNE SYSTEM DISORDER			
HIGH BLOOD PRESSURE				CANCER			
LOW BLOOD PRESSURE				RADIATION/ CHEMOTHERAPY			
STROKE				EYE DISEASE/ GLAUCOMA			
FAINTING OR BLACKOUTS				WEAR CONTACT LENSES/ GLASSES			
ANEMIA				ANXIETY DISORDER			
ABNORMAL BRUISING				PSYCHIATRIC THERAPY			
ABNORMAL BLEEDING				ON A DIET			
HAYFEVER/SINUS TROUBLE				TMJ LIMITED MOUTH OPENING			
DIABETES				MALIGNANT HYPERTHERMIA			
TUBERCULOSIS				JAUNDICE HEPATITIS			
THYROID TROUBLE				LIVER DISEASE			

MEDICATIONS

PLEASE LIST ANY MEDICATIONS YOU ARE NOW TAKING BELOW:

	MEDICATION	DOSAGE	HOW OFTEN
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

ALLERGIES AND DRUG REACTIONS

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

	YES	NO
LOCAL ANESTHETICS……	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS……	☐	☐
SULFA DRUGS……	☐	☐
BARBITURATES, SEDATIVES, SLEEPING PILLS……..	☐	☐
ASPIRIN……	☐	☐
IODINE……	☐	☐
CODEINE OR OTHER NARCOTICS……..	☐	☐
OTHER MEDICATIONS……..	☐	☐

ALLERGIES OTHER THAN DRUGS (FOOD, LATEX, ETC.) _____

_____

CHILDREN ONLY

	YES	NO
HAS YOUR CHILD UNDER THE CARE OF A FAMILY PHYSICIAN OR PEDIATRICIAN…	☐	☐

IF SO WHEN WAS THE LAST VISIT_____

WOMEN ONLY

	YES	NO
IS THERE ANY POSSIBLITY YOU MAY BE OR ARE GOING TO BECOME PREGNANT……..	☐	☐
DATE OF LAST MENSTRUAL PERIOD_____		
ARE YOU NURSING……..	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS……	☐	☐

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I WILL NOT HOLD ANY MEMBER OF HIS STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE DURING THE COMPLETION OF THIS FORM.

DATE_____/_____/_____ SIGNATURE OF PATIENT OR LEGAL GUARDIAN_____