Patient Health History

Name: ______________________ **Age:** __________

Physician: ______________________

Dentist: ______________________

1. Have you been a patient in the hospital during the last two years? YES NO

2. Have you ever had any operations or surgical procedures? YES NO
Please list: ______________________

____

3. Have you been under the care of a medical doctor, including alternative therapy during the past two years? YES NO

4. Have you taken any medicine, herbals or drugs during the past two years? (i.e. Seldane, Acutane, Diet Pills) Please list: ______________________ YES NO

____

5. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by Penicillin, aspirin, codeine, any drug or medication, or latex? YES NO

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

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

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

9. Do you smoke? __________ Packs per day? __________ How long? __________

10. Do you use snuff or chew tobacco? __________ How long? __________

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

12. Circle any of the following 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

Kidney Trouble
Bladder Infection
Stomach Problems
Ulcers
Glomerulonephritis
Glaucoma
Thyroid Disease
Diabetes
Growth Disturbance
Sarcoidsis
Cortisone Injection
Steroid Therapy
Hormone Replacement
Lupus
Arthritis
Rheumatism
Artificial Joint (Replacement)

Stroke
Epilepsy or Seizures
Nervous or Anxious Feeling
Fainting or Dizzy Spells
Poor Circulation

Bleeding Problems
Bruise Easily
Anemia
Sickle Cell Disease
Hemophilia
Blood Disease

Depression	**Hepatitis (Infectious or Serum)**	**Venereal Disease**
Mental Illness	**Liver Disease**	**Gonorrhea**
Psychiatric Treatment	**Yellow Jaundice**	**Syphilis**
Counseling	**Blood Transfusion**	**Genital Herpes**
Drug or Alcohol Abuse	**Immune Disease**	**Cold Sore/Fever Blister**
		Cancer

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

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

15. Do your ankles swell during the day? YES NO

16. Do you use more than 2 pillows to sleep? YES NO

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

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

19. Are you on a special diet? YES NO

20. Has your medical doctor ever said you have a cancer or tumor? YES NO

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

22. Women Only:
  - Are you pregnant now? .... YES NO
  - Do you anticipate becoming pregnant? .... YES NO
  - Do you have children? Number: ________ .... YES NO
  - Were there any delivery complications .... YES NO
  - Are you taking birth control pills? .... YES NO
  - I understand that taking antibiotics may alter the effectiveness of my oral contraceptives.. YES NO

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

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