



HEALTH HISTORY

We thank you for completing this record accurately. Please feel free to ask for assistance if necessary. As with all information contained in your chart, this document is confidential.

Name _____ Date _____

Date of Birth _____ Age _____ Occupation _____

Male Female

1. General Health: Good Fair Poor

YES NO

2. Are you now or have you been under a physician's care during the past 5 years?
 What for? _____

3. Are you currently under a doctor's orders?
 What orders? _____

4. Have you ever had a serious illness?
 What? _____

5. Have you had or are you currently having multiple headaches?
 How frequent? _____ What causes it? _____

6. Have you had or are you currently having neck pain?
 How frequent? _____ What causes it? _____

7. Have you had previous surgeries?
 What? 1 _____ age _____
 2 _____ age _____
 3 _____ age _____
 4 _____ age _____

8. Have you ever had a general anesthetic? (put to sleep for surgery)

9. Have you or anyone in your family had complications with general anesthesia?

10. Do you have diabetes?

11. Have you ever taken a prescription diet medication such as Fen-Phen, Redux or Bisphosphinates?
 How recently? _____ For how long? _____

12. List all Prescription and NON-Prescription drugs, including Aspirin, Tylenol, Advil, etc.

	DOSE	Times when Taken
A		
B		
C		
D		
E		
F		

FOR WOMEN ONLY	YES	NO
13. Are you using an oral contraceptive?	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you pregnant? Due date? _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you trying to become pregnant at this time?	<input type="checkbox"/>	<input type="checkbox"/>
16. Are you aware that an antibiotic may interfere with the function of birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

17. Have you had any of the following?

	YES	NO	If YES, When was this
HEART DISEASE			
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack (Coronary)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal Electrocardiogram (EKG)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	What? _____
Valve replacement?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
LUNG DISEASE			
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes:			
Does aspirin make your asthma worse?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever gone to the emergency room or been admitted to the hospital because of asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use an inhaler regularly?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use a peak flow meter?	<input type="checkbox"/>	<input type="checkbox"/>	_____
(If so, bring this as well as any inhalers you use with you on the day of surgery.)			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYE DISEASE			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Any medications? _____
KIDNEY DISEASE			
GASTRIC (STOMACH) ULCER			
When? _____			
LIVER DISEASE			
Hepatitis (Yellow Jaundice)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
TUMOR OR CANCER			
Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune System Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
HERPES			
Oral <input type="checkbox"/> Genital <input type="checkbox"/>			_____
JOINT DISEASE			
HIP JOINT SURGERY			
Do you have ANY implanted metal joints?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Joint Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Within the last six months, or currently, are you taking:			
A. Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Cortisone (Steroids)	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO
18. Do you smoke or use any tobacco products? How much? _____	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you consume alcohol? How much? _____	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you or have you used illicit drugs? What? _____	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you had fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you wish to speak privately with the doctor about anything?.....	<input type="checkbox"/>	<input type="checkbox"/>
25. Weight _____ Height _____		
26. Are You Allergic To:	YES	NO
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Demerol.....	<input type="checkbox"/>	<input type="checkbox"/>
Novacaine	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>
Other Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>

Name of my Physician _____

Name of my Dentist _____

I was referred by _____

I confirm as true the above Health History Information

Signature _____ Date _____

Parent or Guardian _____ Date _____

FOR OFFICE USE ONLY

This Health History Re-read and Reconfirmed in its entirety and all additions or corrections noted by patient, parent or guardian:

	HEALTH UPDATES	
	Signed	
Date		
Green _____	_____	
Blue _____	_____	

ASA Classification		
I	II	III

Dr. _____ Date: _____

Misc. Information _____
