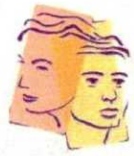

Health History

Today's Date____________ Height________Weight_____

Patient's Name:	Date of Birth:
Responsible Party's Name:	
Street Address:	
City, State, Zip Code:	
Phone Number:	
E-MAIL ADDRESS:	
Emergency Contact (Name & Number):____________________	

Are you in good health? ____________________

DO YOU HAVE OR HAVE YOU EVER HAD:

Answer all questions by circling Yes or No			**All responses are kept confidential:**		
Digestive/Reflux/GI Problems?	Yes	No	HIV/AIDS..	Yes	No
Arthritis..	Yes	No	Liver Disease/Hepatitis............... .	Yes	No
Congenital Heart Disease.................	Yes	No	Blood Disorders/Bruise Easily.......	Yes	No
Any Heart Problems?......................	Yes	No	Seizures, Epilepsy..........................	Yes	No
High Blood Pressure?......................	Yes	No	Kidney Disease..............................	Yes	No
Asthma or Emphysema?.................	Yes	No	Diabetes...	Yes	No
Shortness of Breath, Coughing?......	Yes	No	Thyroid Disease.............................	Yes	No
Stomach Ulcer, Colitis......................	Yes	No	Sinus/Nasal Problems....................	Yes	No
Osteoporosis....................................	Yes	No	Do you smoke?..............................	Yes	No
ANY Implants in your body?...........	Yes	No	Fainting, Dizziness.........................	Yes	No
Emotional Disorders/Depression....	Yes	No	Do you drink alcohol.....................	Yes	No
Are you allergic to latex?...............	Yes	No	History of Drug Use.................	Yes	No

If you answered yes to any of the above, please explain: ____________________

____

Have you ever had a heart attack, stroke or TIA? ____________________

Do you have heart trouble, heart murmur, palpitations, pacemaker, Coronary Artery Disease, Angina, High Blood Pressure, Cardiovascular Disease (if so, please specify)?________________

____

Have you ever had any serious illness, operations or hospitalizations? Please List:

____

____

Are you Pregnant or could you be pregnant? ____________________

Are you taking or have you ever taken Bisphosphonates for osteoporosis (Fosamax, Actonel, Boniva, Aredia, Zometa)? ____________________

Bonita Springs Office . 3388 Woods Edge Circle, Unit 103 Bonita Springs, Florida 34134 **239-947-6637**
Marco Island Office 985 North Collier Boulevard Marco Island, Florida 34145 **239-394-6637**
www.caseysurgicalarts.com
CaseyOmfs@Hotmail.com

Have you ever had any adverse reaction to Local Anesthesia (Novocain, etc.), Codeine, Sedatives or General Anesthesia?

____

Are you allergic to ANY Medication? (Please List)

____

____

____

Please list ALL Medication that you are currently taking, including over the counter medication, vitamins, aspirin, homeopathic remedies, etc.

____

____

____

____

____

Name and Phone Number of your Dentist? ______________________________

____

Name and Phone Number of your Primary Health Care Provider? ______________________________

____

Insurance Information

Insured's Name: ______________________________

Insured's Employer: ______________________________

Insured's Date of Birth: ___ ___ ___

Insurance Company Name, Address and Phone Number:

____

____

____

Insured ID #: ______________________________ Group #: ______________________________

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with Dr. Casey and his medical staff.

Sign______________________________ Date:______________________________

Review by: ______________________________