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# HEALTH HISTORY Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

How did you learn of our office? (circle all that apply)

**Word of mouth Internet Website Friends I’m A Previous Patient of Dr. A**

To Our Patients: BMI (office use)

Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

**\***AGE: ­­­­\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT:\_\_\_\_\_ OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***REASON FOR YOUR VISIT TODAY?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***LIST YOUR SIGNIFICANT MEDICAL PROBLEMS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Both current and past)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\***LIST YOUR PREVIOUS OPERATIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(And Approximate Dates)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? (Including local anesthesia, Iodine, tape, etc.)

WHAT HAPPENS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, AMOUNT AND HOW OFTEN:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Have you been on steroids (Cortisone/Prednisone) in the last year? |  |  |
| Do you currently smoke? If yes, how much per day? |  |  |
| Do you drink alcohol? IF yes, Frequently\_\_\_ Occasionally\_\_\_ Rarely\_\_\_ Amount\_\_\_ |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HAVE YOU HAD OR DO YOU CURRENTLY HAVE… | Yes | No | **HAVE YOU HAD OR DO YOU CURRENTLY HAVE...** | ***Yes*** | No |
| 1. Rheumatic Fever? |  |  | 19. Pulmonary Edema, Pulmonary  Embolus, DVT (leg clots)? |  |  |
| 2. Damaged heart valves/mitral valve  prolapse? Heart Murmur? |  |  | 20. Convulsion, Epilepsy? |  |  |
| 3. Do you pre-medicate when you go to  the dentist? |  |  | 21. Stroke? |  |  |
| 4. High Blood Pressure? |  |  | 22. Thyroid Trouble? |  |  |
| 5. Low Blood Pressure? |  |  | 23. Diabetes? |  |  |
| 6. Chest Pain, Angina? |  |  | 1. Are you on Dialysis? |  |  |
| 7. Heart Attack(s)? |  |  | 1. Stomach Ulcers? |  |  |
| 8. Irregular Heart Beat? |  |  | 1. Fever blisters of the lips? |  |  |
| 9. Cardiac Pacemaker? |  |  | 1. AIDS or HIV infection? |  |  |
| 10. Asthma? |  |  | 1. Problems of the Immune System? |  |  |
| 11. Tuberculosis? (if yes circle)  **ACTIVE INACTIVE** |  |  | 1. Mental Health Problems? |  |  |
| 12. Emphysema? |  |  | 1. Dry Eye Symptoms? |  |  |
| 13. Shortness of Breath with walking? |  |  | 1. Contact Lenses? |  |  |
| 14. Blood Disorder such as anemia? |  |  | 1. Eye Disease/Glaucoma? |  |  |
| 15. Bleeding Tendency (Abnormal  Bleed?) (excessive from a cut or  tooth extraction) |  |  | 1. Radiation Treatment or   Chemotherapy? |  |  |
| 1. HEPATITIS: (if yes circle)   **A B C** |  |  | 1. Blood Transfusion? |  |  |
| 17. Jaundice, Hepatitis or Liver  Disease? |  |  | 35. Do you form large scars or keloids? |  |  |
| 18. Pain in your Calves with Walking? |  |  | 36. Do you use a CPAP at night? |  |  |
| 19. Do you snore? |  |  | 37. Do you have a family history of unexpected death(s) following general anesthesia or exercise; a family or  personal history of MH, a muscle or neuromuscular disorder, high temperature following exercise; a personal  history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following  Anesthesia or serious exercise? |  |  |

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Patient

I have reviewed the information provided by the patient on this history and physical form. I further discussed with the patient any pertinent medical responses.

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Date Signature of Physician