

PATIENT HEALTH HISTORY (Page 1 of 2)

DATE: _____

NAME: _____ AGE: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____

Please state the reason you are seeing the doctor: _____

Do you use any form of tobacco? Yes No How Much? _____ How Long? _____

Are you presently taking any medications, vitamins, herbal or steroid supplements? Yes No
List Medication/Supplement Name Dosage and How often taken:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take vitamin, herbal or steroid supplements? Yes No

Do you use any medicated skin creams, ointments? Yes No

Are you allergic to any medications? Yes No

List Medication Name and Type of Allergic Reaction Experienced:

Allergic to: Shellfish Yes No Iodine Yes No

Do you take aspirin or aspirin products routinely? Yes No

Have you ever had a surgical operation? Surgery Type and Date _____ _____	Have you ever had any cosmetic operations? Surgery Type and Date _____ _____
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Have you had anesthesia? Yes No Has anyone in your family been diagnosed with Malignant Hyperthermia? Yes No

Have you or anyone in your family had any allergic or other reactions to anesthesia? Yes No
List Date and Medical Condition Suffered _____

Family History: Do you have a family history of any of the following disorders?

- | | | |
|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding or Blood Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis (T.B.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertension |

General Health (Circle One): GOOD FAIR POOR

The above information is true and correct to the best of my knowledge.

Signature of Patient or Responsible Guardian

Have you ever had any of the following problems?

LUNGS (PULMONARY)	YES	NO
Asthma	_____	_____
Tuberculosis (T.B.)	_____	_____
Chronic or Frequent Cough	_____	_____
Shortness of Breath	_____	_____
Abnormal Chest X-Ray	_____	_____
Lung Disease	_____	_____
Chronic Nose/Sinus Complaints	_____	_____
Shortness of Breath	_____	_____
Abnormal Chest X-Ray	_____	_____
Smoking	_____	_____

HEMATOLOGIC	YES	NO
Blood Clots in Your Legs	_____	_____
Pulmonary Embolism	_____	_____
Phlebitis	_____	_____
Varicose Veins	_____	_____
Spider Veins	_____	_____
Blood Clotting Abnormalities	_____	_____
Blood or Plasma Transfusion	_____	_____
Hemophilia	_____	_____
Recurrent Nosebleeds	_____	_____

GASTROINTESTINAL	YES	NO
Jaundice or Hepatitis	_____	_____
Liver Disease	_____	_____
Stomach Ulcers	_____	_____
Frequent Heartburn	_____	_____
Hernia	_____	_____

RENAL	YES	NO
Kidney Disease/Stones	_____	_____
Frequent Bladder Infections	_____	_____
Prostate Problems	_____	_____

SKIN	YES	NO
Skin Cancer	_____	_____
Hives, Eczema, Rashes	_____	_____
Form Large Scars/Keloids	_____	_____
ACTH/Steroid Medications (Excluding skin creams/lotions)	_____	_____
Allergic to Latex or Suture	_____	_____
Frequent Infections/Boils	_____	_____
Cold Sores/Fever Blisters	_____	_____
Genital Herpes	_____	_____

NEUROLOGICAL	YES	NO
Stroke	_____	_____
Fainting Spells	_____	_____
Convulsions	_____	_____
Epilepsy	_____	_____
Migraine Headaches	_____	_____
Adult Attention Deficit Disorder	_____	_____
Migraine Headaches	_____	_____
Bipolar	_____	_____

CARDIOVASCULAR	YES	NO
Mitral Valve Prolapse	_____	_____
Anemia	_____	_____
High Blood Pressure	_____	_____
Chest Pain/Angina	_____	_____
Heart Attack	_____	_____
Irregular Heartbeats	_____	_____
Rheumatic Fever	_____	_____
Heart Murmurs	_____	_____
Heart Block	_____	_____
Low Potassium	_____	_____
Abnormal EKG (Heart Recording)	_____	_____
Pacemaker	_____	_____
Any Heart Disease	_____	_____
Sickle Cell Disease	_____	_____

MUSCULOSKELETAL	YES	NO
Chronic Back/Neck Pain	_____	_____
Arthritis	_____	_____
Bone, Joint, Muscle Trouble	_____	_____

METABOLIC	YES	NO
Recent Unexpected Weight Loss/Gain	_____	_____
Diabetes	_____	_____
Thyroid/Goiter Problems	_____	_____
Night Sweats/Fever	_____	_____
AIDS (HIV +)	_____	_____
Sensitive to Cold Temperatures	_____	_____
Changes in Skin	_____	_____
Loss of Hair	_____	_____
Loss in Libido (Sex Drive)	_____	_____
Decrease in Vaginal Lubrication	_____	_____
Frequent Constipation	_____	_____
Menstrual Changes	_____	_____

VISION	YES	NO
Glaucoma	_____	_____
Loss of Vision	_____	_____
Wear Glasses or Contacts	_____	_____

MENTAL	YES	NO
Do you have, or have you had emotional problems?	_____	_____
Any recent emotional crisis?	_____	_____
Have you been verbally or sexually abused?	_____	_____

PREGNANCY	YES	NO
Any possibility you are pregnant?	_____	_____
Have you had a tubal ligation or hysterectomy?	_____	_____

MAMMOGRAM	YES	NO
Have you had a mammogram?	_____	_____
If yes, when?	_____	_____

Signature of Patient or Responsible Guardian