

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

### HEALTH HISTORY

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? \_\_\_\_\_         
a. How frequent? \_\_\_\_\_ What causes it? \_\_\_\_\_
6. Have you had or are you currently having neck pain? \_\_\_\_\_         
a. How frequent? \_\_\_\_\_ What causes it? \_\_\_\_\_
7. Have you had previous surgeries? What? \_\_\_\_\_ Age?         
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_
8. Have you ever had a general anesthetic? (put to sleep for surgery) \_\_\_\_\_
9. Do you have Sleep Apnea or do you severely snore? \_\_\_\_\_
10. Have you or anyone in your family had complications with general anesthesia? \_\_\_\_\_
11. Do you have Diabetes? \_\_\_\_\_
12. Have you ever or are you currently taking diet medication; Fen-Phen, Redux or GLP-1? \_\_\_\_\_
13. Have you ever or are you currently taking a Bisphosphonates? \_\_\_\_\_         
a. How recently? \_\_\_\_\_ For how long? \_\_\_\_\_
14. Do you have Osteoporosis or bone cancer? \_\_\_\_\_

### NEUROLOGIC

Dementia \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_  
 Alzheimer \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_  
 Parkinson's Disease \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_  
 Epilepsy \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_

### MEDICATIONS

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

	DOSE	Times When Taken
A		
B		
C		
D		
E		

20. Have you had any of the following?

	YES	NO	IF YES, WHEN WAS THIS?
<b>HEART DISEASE</b>			
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? yes <input type="checkbox"/> no <input type="checkbox"/>			
Pacemaker _____	<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"/>	_____
<b>LUNG DISEASE</b>			
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? _____	<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"/>	_____
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>EYE DISEASE</b>			
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	Any medication? _____
<b>KIDNEY DISEASE</b> _____			
<b>GASTRIC (STOMACH) ULCER</b> _____			
<b>LIVER DISEASE</b> _____			
Hepatitis (Yellow Jaundice) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cirrhosis _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>TUMOR OR CANCER</b> _____			
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 _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>JOINT DISEASE</b>			
<b>HIP JOINT SURGERY</b> _____			
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"/>	_____
<b>Within the last six months, or currently,</b> are you taking?			
a. Blood Thinners _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Cortisone (Steroids) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | YES                      | NO                       |
| 21. Do you smoke or use any tobacco products? How much? _____            | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you consume alcohol? How much? _____                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you or have you used illicit drugs? What? _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you had seizures? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Have you had fainting spells? _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you wear contact lenses? _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you wish to speak privately with the doctor about anything? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Height _____ Weight _____  |                          |                          |

<b>FOR WOMEN ONLY</b>	<b>YES</b> <b>NO</b>
16. Are you using an oral contraceptive? _____	
17. Are you pregnant? Due Date? _____	
18. Are you trying to become pregnant at this time? _____	
19. Are you aware that an antibiotic may interfere with the function of birth control pills?	

- |                             |                          |                          |
|-----------------------------|--------------------------|--------------------------|
| <b>Are You Allergic To:</b> | <b>YES</b>               | <b>NO</b>                |
| 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"/> |
| Soy/Eggs _____              | <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 \_\_\_\_\_

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

	<b>HEALTH UPDATES</b>			
	Date	Signed		
Green _____	_____	_____		
Blue _____	_____	_____		

**ASA Classification**

<b>I</b>	<b>II</b>	<b>III</b>
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Dr. \_\_\_\_\_ DATE: \_\_\_\_\_

Misc. Information

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