

Patient History Form

BP _____ WT _____ HT _____

➤ **Allergies:** please list all allergies including medications, food, and anything environmental

<u>Allergy</u>	<u>Reaction</u>	<u>Allergy</u>	<u>Reaction</u>

❖❖ Does your skin break out when exposed to: Metal **Y N** Latex **Y N**

➤ **Medications:** Please list ALL current medications you are taking including vitamins, herbals, etc.

<u>Medication</u>	<u>Dose and Frequency</u>	<u>Medication</u>	<u>Dose and Frequency</u>

➤ **Health History** Please check yes or no. If yes, please explain (including date if possible)

• <u>Cardiac</u>	Yes or No		
Heart Disease	Y	N	
Chest Pain	Y	N	
Heart Attack	Y	N	
Irregular Heartbeat	Y	N	
Pacemaker	Y	N	
High Blood Pressure	Y	N	
Cardiac Stent (s) Placed/Bypass	Y	N	When?
• <u>Hematologic</u>			
Anticoagulation / Blood Thinner	Y	N	
Recent Aspirin use	Y	N	
Recent Anti-inflammatory use	Y	N	
Bleeding Problems	Y	N	
Blood Clots	Y	N	
Blood Transfusion	Y	N	
• <u>Respiratory</u>			
Sleep Apnea	Y	N	
Use a CPAP / BiPAP	Y	N	
Asthma	Y	N	
Wheezing	Y	N	
Bronchitis	Y	N	
Pneumonia	Y	N	
Emphysema	Y	N	
COPD	Y	N	
Current oxygen use at home	Y	N	How many liters?

➤ **Health History Continued**

Please check yes or no. If yes, please explain (including date if possible)

	Yes or No		
• Neurologic			
Epilepsy / Seizures	Y	N	
Severe Headaches / Migraines	Y	N	
Stroke	Y	N	
Spinal Cord Injury	Y	N	
Other: please specify below	Y	N	
• Endocrine			
Diabetes	Y	N	
Thyroid Disease	Y	N	
Cortisone/Steroid use in past year	Y	N	
• Renal			
Kidney Disease	Y	N	
Prostate Problems	Y	N	
Could you be pregnant	Y	N	
• GI / Hepatic			
Liver Disease	Y	N	
Hepatitis	Y	N	
Jaundice	Y	N	
Indigestion	Y	N	
Special Diet	Y	N	
• Skeletal			
Arthritis	Y	N	
Rheumatoid or Inflammatory	Y	N	
Gout	Y	N	
Broken bones in the past	Y	N	Please list/Explain:
Neck Problems	Y	N	
Back Problems	Y	N	
Any current physical restrictions	Y	N	
• Psychologic			
Mental Illness / Depression	Y	N	
Do you suffer from PTSD?	Y	N	
• Other			
Cancer	Y	N	
HIV Positive / AIDS	Y	N	
Chronic Infections (i.e. MRSA)	Y	N	
Recent weight loss	Y	N	

➤ **Surgical/Hospitalization History** (include dates and facilities if possible)

Date	Surgery / Hospitalization	Facility	Problems with Anesthesia?

➤ Review of Systems (have you had any of the following symptoms in the last few months)

Fevers	Y N	Joint Pain	Y N
Vision Problems	Y N	Skin Infections / Problems	Y N
False / capped / loose teeth	Y N	Balance Problems	Y N
Swelling of Extremities	Y N	Mood Problems	Y N
Recent cough, cold, or sore throat	Y N	Night Sweats	Y N
Diarrhea / Nausea / Vomiting	Y N	Bruise Easily	Y N
Difficulty with Urination	Y N	Hayfever or other allergies	Y N

➤ Social History

Tobacco Use	Y N	Start Date?	Stop Date?	How much?	Cigarette?	Pipe?	Chew?
Alcohol use and amount	Y N	Start Date?	Stop Date?	How much?			
Do you use street drugs	Y N	Start Date?	Stop Date?	How much?	Type?		
Have you had the flu shot	Y N	Date?					
Have you had a pneumonia shot	Y N	Date?					
Do you have a nickname or prefer to go by a different name:							
What do you do for a living:							
Who is your Primary Medical Doctor and what is their phone number:				Who is your emergency contact and their phone number:			
_____				_____			
What Pharmacy do you prefer to use and city:				Do you have an Advanced Directive: Y N			
				* If so, please provide a copy for your chart			

➤ Family Medical History (include person affected - Maternal / Paternal)

<u>Major Medical Problem</u>	<u>Relationship to patient</u>
Any blood relatives having trouble with anesthesia? e.g. Malignant Hyperthermia	Y N Relative(s): _____

Other Pertinent Information (e.g. Lupus, MS, etc.) _____

DISCLAIMER: I UNDERSTAND THAT QUESTIONS NOT ANSWERED WILL BE CONSIDERED NO, NONE, OR NOT APPLICABLE.

Patient Signature: _____ Date: _____

Reviewed By / Date: _____ Reviewed By / Date: _____