



Patient Health History

Name: _____

Date of Birth: ____/____/____

Reason for Visit Today: _____

Timeframe for Scheduling Surgery: _____

Number of Children: _____ Ages of Children: _____

Any adverse Reaction to Anesthesia? _____

Currently Taking Steroids, or within the past year? _____

Have you been exposed to, or have any infectious disease? _____

Have you had any significant weight change in the past year? _____

Have any major changes occurred in your family in the past year (death, divorce, illness, etc.)? If so, please explain. _____

Have you received psychological counseling in the past 5 years? _____

List Medications, Supplements or None:	Dose:	How Often Taken:

List Allergies (Drug, Tape, Food) or None:	Reaction:

List Surgeries (including cosmetic):	Date:

Most recent mammogram date and results: _____

Please indicate usage and frequency of the following:

Alcohol ___ (x per week) Tobacco ___ (x per day) Vaping ___ (x per day) Marijuana ___ (x per day)

Family History of:

___ Bleeding disorder, Who? _____ ___ Diabetes, Who? _____
___ Stroke, Who? _____ ___ Anesthesia reaction, Who? _____
___ Heart Disease, Who? _____
___ Cancer, What type and who? _____

Have you ever had any of the following conditions? Please indicate with a check mark.

___ Blood Clots	___ Lung Disease	___ Diabetes
___ Easy Bruising/Bleeding	___ Asthma	___ Acid Reflux/Ulcer
___ Bleeding Gums	___ Shortness of Breath	___ Hernia
___ Nose bleeds	___ Chronic Cough	___ Nausea/Vomitting
___ Anemia	___ Cold Sores	___ Change in Bowel Habits
___ Blood in Urine	___ Migraines	___ Difficulty in Urination
___ High Blood Pressure	___ Seizures	___ Diabetes
___ Heart disease/Stroke	___ Nerve Damage	___ Thyroid Disease
___ Pacemaker	___ Loss of Consciousness	___ Liver Disease
___ Heart Attack	___ Swelling of Hands/Feet	___ Kidney Disease
___ Irregular Heart Beat	___ Dry Eyes	___ Joint Stiffness/Decreased Mobility
___ Heart Murmur	___ Blurred Vision	___ Chronic Pain
___ Mitral Valve Prolapse	___ Cornea Problems	___ Depression/Anxiety
_____ Cancer/Type	___ Drug/Alcohol Abuse	___ Psychiatric Condition

Please list any conditions you have had not listed above: _____

Today's Date: ___/___/_____ Patient's signature: _____