Patient Health History Form page 1

Patient Name:______________________________ **Age:**_______ **Date of Birth:**___________

Name of Physician requesting this consultation:______________________________

Chief Complaint

Reason for today's visit? ______________________________

____

Past History

Please list any prior major illnesses and/or injuries:

____

____

____

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia: ______YES ______NO

Current Medication(s) including Aspirin	Dose	Frequency

ALLERGIES/REACTIONS TO MEDICATIONS, ANESTHETIC OR MATERIALS:

Family History

Do you have a family history of trouble with anesthesia? _____YES ______NO

Do you have a family history of easy bleeding? _____YES _____NO

Social History

Do you smoke? _____YES, I've smoked __________ packs of cigarettes per day for __________ years.

_____YES, I smoke cigars or a pipe

_____NO, I have never smoked

_____NO, I quit _____years ago. At that time I was smoking _______packs a date for _______years.

Do you drink alc _____NO, never (or rarely)

_____NO, but I used to

_____YES, _____daily _____1 or more times a week _____1 or more time a month

Substance Abuse:

Which of the following, if any, have you used in the past? (Circle all that apply) Indicate ("O")occasional, ("F")frequently, or ("C")continuously

Barbiturates_________ Cocaine ___________ Other ______________

Amphetamines ________ Marijuana __________ (specify)

Are you presently using any of the drugs or substances below? (Circle all that apply) Indicate ("O")occasional, ("F")frequently, or ("C")continuously

Barbiturates_________ Cocaine ___________ Other ______________

Amphetamines ________ Marijuana __________ (specify)

Review of Systems

Are you currently, or have you had, problem with:

Constitutional	***Circle One***	
Weight gain	YES	NO
Weight loss	YES	NO
Night Sweats	YES	NO
Insomnia	YES	NO
Eyes		
Double vision	YES	NO
Visual loss	YES	NO
Ear, Nose, Throat and Mouth		
Hearing loss	YES	NO
Noise/ringing in ears	YES	NO
Nasal congestion	YES	NO
Nasal drainage	YES	NO
Sore throat	YES	NO
Trouble swallowing	YES	NO
Hoarseness	YES	NO
Cardiovascular		
Chest pain or angina	YES	NO
Heart trouble	YES	NO
Rheumatic fever	YES	NO
Heart murmur	YES	NO
High blood pressure	YES	NO
Respiratory	***Circle One***	
Asthma	YES	NO
Cough up blood	YES	NO
TB	YES	NO
Pneumonia	YES	NO
Trouble breathing at night	YES	NO
Snoring	YES	NO
Gastrointestinal		
Indigestion or heartburn	YES	NO
Ulcer	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Blood in stool	YES	NO
Black, tarry stools	YES	NO

I have reviewed the above information with the patient.

_______________________________ __________

Physician Signature Date

_______________________________ __________

Physician Signature Date

Physician Signature Date

Genitourinary	***Circle One***	
Bladder trouble	YES	NO
Prostate disease	YES	NO
Kidney disease	YES	NO
Musculoskeletal		
Arthritis	YES	NO
Neurological		
Numbness	YES	NO
Weakness	YES	NO
Stroke	YES	NO
Headache	YES	NO
Psychiatric		
Depression	YES	NO
Endocrine		
Diabetes	YES	NO
Thyroid disease	YES	NO
Hematologic		
Bleeding disorder	YES	NO
Easy bleeding	YES	NO
Allergic/Immunologic		
Sneezing	YES	NO
Itchy eyes/nose	YES	NO
Itchy throat	YES	NO
Skin rash	YES	NO
HIV	YES	NO

Are you working at this time? YES NO

If Yes: Part-time Full-time

Date last worked:_______________________________________

If not working, reason:___________________________________

____

Do you have a sedentary job? YES NO

Are you working without restrictions? YES NO

List restrictions:_______________________________________

The above information is accurate to the best of my knowledge.

____________________________________ ____________

Patient Signature Date