HEALTH HISTORY

Patient Name________________________________Age_______Surgeon__________________________

Medication allergies:____

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Allergic to latex ?_____reaction_______________Allergic to Seafood/Iodine?_____reaction___________

Have you ever had problems with anesthesia?____explain____

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Current Prescription Medications____

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Aspirin/Ibuprofen/Other OTC's, please list__ ____________How much & how often?______________ __

Please list a*ll* previous surgeries

Brain/Eyes_____________________________
Neck, Carotids, Tonsils____________________
Heart__________________________________
Liver/Gallbladder_________________________
Esophagus/stomach________________________
Colon/Small bowel________________________
Spine__________________________________
Uterus/Ovaries___________________________
Skin___________________________________

Thyroid/Parathyroid__________________________
Breast__________________________________
Lung___________________________________
Appendix________________________________
Kidney_________________________________
Rectum, Anus_____________________________
Arms/Legs/Joints__________________________
Bladder/Prostate__________________________
Other___________________________________

Medical History-*please check all that apply*

General: Chronic fever______ Excessive weight loss______ Other__________________________

Eyes: Glasses____ Cataracts____Glaucoma____Vision loss____Other____________________

Ear/nose/throat: Hearing loss____Seasonal allergies____Sinus infections_____Dentures_____
Sore throats____Hoarseness____Other__________________

Heart: Heart attack____Chest pain/angina____Heart murmer____High blood pressure____
Palpitations____Atrial fibrillation____Rheumatic fever____Pacemaker____CHF____
Heart valve____Congestive heart failure____**Coumadin**______Other_______________

Lungs: Asthma____Emphysema____Wheezing____Shortness of breath____Sleep Apnea____
Chronic cough____Home oxygen____Tuberculosis____COPD____Other____________

Gastric/bowel: Nausea____Vomiting____Pain____Change in stool____Color____Frequency____
Rectal bleeding____Hemorrhoids____Jaundice/Hepatitis____Other_________________

Skin: Melanoma____Skin cancers____Rashes____Moles____Keloids____Other___________

Muscle/bone: Back pain____Joint pain____Sciatica____Slipped disc____Other___________________

Nerve: Stroke____Seizures/Epilepsy____Blackouts____Migraines____Polio____Other_______

Psych: Anxiety____Depression____Phobias____Sleeping pills____Other___________________

Endocrine: Diabetes____Thyroid____Cholesterol____Other___________________________________

Hematologic: Anemia____Mononucleosis____Swollen glands____Sickle cell____
Clotting problems____Other____

Immune: Steroids____Arthritis____Chemotherapy____HIV____Other______________________

Urinary: Kidney Stones____UTI's____Problems with urination __________________________
Male: Prostate problems____Testicular problems____Other_______________________
Female: Menopause(when)_______Last menstrual cycle___________Hormones_______

Please continue next page

continued

Social history:

Smoker____how much______________________how long________________Quit_________

Drink alcohol____how much_________________how often________________Quit________

Please list any specialists you have seen in the past 5 years, for example: heart, lung, oncology, GI, OB/GYN, etc.:

Please list any recent hospitalizations:

Please list any recent medical tests/procedures you have recently had, such as x-rays, ultrasound, labwork, scopes, biopsies, etc:
Please include when and where they were done:

Please list any ongoing treatment such as dialysis, infusions, injections, etc

Family history: *Please inform us of any family history that may be helpful to your care:*

Patient signature____Date_____________________

Please do not write below this line

DR's and nurse's notes:

Nurse signature____Date___________________________

Physician signature____Date___________________________

Date/Initials_______________ Date/Initials________________ Date/Initials__________________
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