HEALTH HISTORY

Patient's Name **AGE** **Height/Weight** **Sex** **Date**

Answer all questions by circling Yes (Y) or No (N)

DO YOU HAVE OR HAVE YOU EVER HAD:

A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
B. Congenital Heart Disease? ....Y N
C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ....Y N
D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ....Y N
E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?...Y N
F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?............Y N
G. Liver Disease (Jaundice, Hepatitis)?......................Y N
H. Kidney Disease?..Y N
I. Diabetes?..Y N
J. Thyroid Disease (Goiter)?.......................................Y N
K. Arthritis?...Y N
L. Stomach Ulcers or Colitis?.....................................Y N
M. Glaucoma?...Y N
N. Osteoporosis?..Y N
O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?..................Y N
P. Radiation (X-ray) treatment for Cancer?................Y N

ARE YOU USING ANY OF THE FOLLOWING:

A. Antibiotics?..Y N
B. Anticoagulants (Blood Thinners)?..........................Y N
C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
D. High Blood Pressure medications?.........................Y N
E. Steroids (Cortisone, Prednisone, etc.)? ....Y N
F. Tranquilizers? ....Y N
G. Insulin or Oral Anti-Diabetic drugs? ....Y N
H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
I. Have you ever been advised <u>not</u> to take a medication? ....Y N
J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:______________________________________
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ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

A. Local Anesthesia (Novacain, etc.)? ....Y N
B. Penicillin or other antibiotics? ....Y N
C. Sedatives, Barbiturates? ....Y N
D. Aspirin or Ibuprofen? ....Y N
E. Codeine or other pain killers?.................................Y N
F. Latex or Rubber products? ....Y N
G. Metal of any kind? ....Y N
H. Chemicals or jewelry (rash or sensitivity)? ....Y N
I. Food products? ....Y N
J. Other allergies or reactions? Please list ....Y N
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Do you smoke or chew Tobacco? ....Y N
How much per day? _________

Have you or an immediate family member had any problem associated with intravenous anesthesia?.........Y N

Do you wish to speak to the doctor privately about anything?...Y N

FOR WOMEN ONLY

A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ....Y N
B. Are you nursing? ....Y N
C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of patient (Parent or Guardian if minor):____________________________________ Date:________________
Relationship to patient:_____________________

I Hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Signature of patient (Parent or Guardian if minor)__________________________________Date:___________