

Confidential Health History

Please review the following list of conditions and questions and **check all items** appropriate to your medical history.

Past Medical History

Medical Condition	Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or TIA's	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Valve	<input type="checkbox"/>	<input type="checkbox"/>
Heart Flutter	<input type="checkbox"/>	<input type="checkbox"/>
Angina (chest pains)	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Chest cold last 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>
<u>Bleeding problem</u>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Do you take dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Reflux Disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Attacks	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint(s)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (high blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>
Do you use Insulin?	<input type="checkbox"/>	<input type="checkbox"/>
If so give type & amount:		

Do you wear contacts?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Write in any condition that applies to you that we have not listed:		

Physician _____
Last Visit _____
Dentist _____
Last Visit _____

Medications

Please list any medications you take including aspirin and birth control pills:

Medication Allergies

Please list any medications to which you are allergic:

Past Surgical History

Past Surgery	Yes	No
Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Ear Tubes	<input type="checkbox"/>	<input type="checkbox"/>
Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>
Bypass surgery	<input type="checkbox"/>	<input type="checkbox"/> # of vessels _____
Gall Bladder removed	<input type="checkbox"/>	<input type="checkbox"/>
Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Valve	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
General Anesthesia (GA)	<input type="checkbox"/>	<input type="checkbox"/>
Complications with GA	<input type="checkbox"/>	<input type="checkbox"/>
Write in any surgery that you have had that is not listed:		

Have you ever been told you need antibiotics before surgery or dental treatment to protect your heart or an artificial joint <input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you ever taken FenPhen or Redux <input type="checkbox"/> Yes <input type="checkbox"/> NO		

Social

Do you smoke?
 Yes No

If Yes, how many packs per day?

Do you drink alcohol?
 Yes No

If Yes, how often?
 Daily
 Weekends
 Rarely

Are you allergic to Latex?
 Yes No

Authorization & Release – I certify that I have read and understand the information above to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the surgeon to release any information including diagnosis and record of any treatment or examination rendered to me or my child to Medical or Dental offices and/or third party payers.

SIGNED: _____ Date: _____