

Confidential Health History

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

Past Medical History

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

Do you wear contacts?		
/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

<u>Past Surgery</u>	<u>Yes</u>	<u>No</u>
Tonsillectomy		
Appendectomy		
Ear Tubes		
Angioplasty		
Hysterectomy		
Tubal Ligation		
Bypass surgery		# of vessels _____
Gall Bladder removed		
Hernia Repair		
Artificial Valve		
Artificial Joint		
General Anesthesia (GA)		
Complications with GA		
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	YES	NO
Have you ever taken FenPhen or Redux	Yes	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: _____