HEALTH HISTORY FORM

Date	Patient Name	Age	Weight	Height

Email Address:

Medical History – Please check if you have, or have had any of the following

- ☐ Angina
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Heart Surgery (explain)
- ☐ Asthma
- ☐ Pneumonia
- ☐ tuberculosis
- ☐ Emphysema
- ☐ Sinus Problems
- ☐ Convulsion/Seizures
- ☐ Stroke
- ☐ Hepatitis or other Liver Disease
- ☐ Ulcers
- ☐ Arthritis
- ☐ Diabetes
- ☐ Kidney disease
- ☐ glaucoma
- ☐ Thyroid Disease
- ☐ anemia
- ☐ Bleeding Disorder
- ☐ Leukemia
- ☐ Cancer (List type below)
- ☐ HIV / AIDS
- ☐ venereal disease
- ☐ Depression
- ☐ Psychiatric Care
- ☐ Drug Addiction

Other Medical conditions

OB/GYN History

No. of time Pregnant | No. of Births | No. of Abortions | No. of miscarriages

Past Surgeries – Including cosmetic surgeries

Operation(s)	Surgeon / Hospital	Year	Anesthesia
			☐ Local ☐ Intravenous ☐ General Anesthesia
			☐ Local ☐ Intravenous ☐ General Anesthesia
			☐ Local ☐ Intravenous ☐ General Anesthesia
			☐ Local ☐ Intravenous ☐ General Anesthesia

Have you ever had difficulties with: Local Anesthesia ☐ Yes ☐ No Intravenous Anesthesia ☐ Yes ☐ No

Medication allergies & type of reaction	Current medication(s) - (including diet pills)

Family History – Please list illnesses and who had it

Social History	Approximate Daily consumption: Alcoholic beverages		cigarettes	

Systems Review – Please check if you experience any of the following

HEAD
- ☐ Headaches
- ☐ Lightheadedness
- ☐ vertigo

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Shortness of Breath
- ☐ Palpitations
- ☐ Irregular Heartbeats
- ☐ Bleeding Problems

RESPIRATORY
- ☐ Chronic cough
- ☐ Bloody Sputum
- ☐ Sinus Infection
- ☐ Wheezing
- ☐ Nasal Drips
- ☐ Trouble Breathing

HEARING/VISION
- ☐ difficulty hearing
- ☐ Poor vision
- ☐ double vision

GASTROINTESTINAL
- ☐ Nausea
- ☐ vomiting
- ☐ Difficulty swallowing
- ☐ ulcers
- ☐ bloody stool
- ☐ chronic indigestion

GENITOURINARY
- ☐ Blood in urine
- ☐ discharge
- ☐ Difficulty with urination

NEUROMUSCULAR
- ☐ Loss of consciousness
- ☐ Seizures
- ☐ Numbness
- ☐ Paralysis
- ☐ Joint disorders

MISCELLANEOUS
- ☐ sensitive to heat or cold
- ☐ Recent weight change
- ☐ Irregular menses
- ☐ Prolonged menstrual flow

Other medical symptoms

Recent examinations – Date of most recent exam or tests

- ☐ history & physical dates:
- ☐ OB/gynecologic dates:
- ☐ Mammogram dates:
- ☐ Chest x-ray dates:
- ☐ laboratory tests dates:
- ☐ EKG dates:

I acknowledge that the above information is true to the best of my knowledge. If there are any changes in my health or medications, I will inform the physician.

Signature: **Date:**

Medical History Reviewed & changes added:	Initial:	Date:	Initial:	Date: