

**HEALTH HISTORY**

1. Today's Date: \_\_\_\_\_

2. Name: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Primary Care Doctor: \_\_\_\_\_

5. Referring Doctor ( if different ) \_\_\_\_\_

6. Reason for today's visit:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Do you have any health problems? If yes please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Medications: - Please list all prescription and non-prescription medications you take including vitamins and herbs with dosage. (e.g. Penicillin 500mg. 4x daily) If none

_____	_____
_____	_____
_____	_____
_____	_____

9. Do you have any medication allergies? No  Yes  If so, please list below.

\_\_\_\_\_ Reaction: \_\_\_\_\_

10. Do you smoke? No  Yes  How much and for how long? \_\_\_\_\_

11. Do you ever use alcohol? No  Yes  How much? \_\_\_\_\_

12. Are you allergic to: latex (e.g. dentist gloves)? No  Yes  Reaction: \_\_\_\_\_

13. Have you been treated with steroids in the past 2 years?(e.g., prednisone, Medrol) \_\_\_\_\_

14. Please list past surgeries with dates (month/year) and if you experienced any problems during or after surgery. (i.e. anesthesia problems, nausea or vomiting)

\_\_\_\_\_

\_\_\_\_\_

15. Who would be available to care for you and stay overnight with you if you need to have surgery?

\_\_\_\_\_

16. Does anyone in your family (blood relatives) have high fever from anesthesia? Bleeding, healing or scarring problems? \_\_\_\_\_

17. Social history: Town of residence \_\_\_\_\_

Marital status (optional) \_\_\_\_\_

Who are the members of your household and their ages? \_\_\_\_\_

\_\_\_\_\_

What do you do for work? \_\_\_\_\_

What do you enjoy or do for fun? \_\_\_\_\_

\_\_\_\_\_

18. Please check if you have or have had any of the following conditions. (please specify)

Yes No

Difficulties with eyes, ears, nose or throat \_\_\_\_\_

Thyroid trouble or diabetes \_\_\_\_\_

Heart or circulation problems or increased blood pressure \_\_\_\_\_

Lung problems \_\_\_\_\_

Gastrointestinal difficulties or digestive trouble/liver problems \_\_\_\_\_

Kidney or urinary tract problems \_\_\_\_\_

Difficulties with male or female organs/breasts \_\_\_\_\_

Trouble with balance or coordination/feeling in your hands or feet? \_\_\_\_\_

Neurological or nerve problems (e.g. seizures, slipped disc) \_\_\_\_\_

Skin difficulties \_\_\_\_\_

Arthritis, rheumatism or trouble with your muscles \_\_\_\_\_

Bleeding, anemia or blood diseases \_\_\_\_\_

Highs or lows of mood or panic attacks \_\_\_\_\_

19. If you are a woman when was your last mammogram? \_\_\_\_\_