

History and Physical

Name: _____ Date: _____

SOCIAL

Age: _____ Sex: M or F Married: Y or N Occupation: _____

HABITS

Smoke: Y or N Amount: _____ Coffee/Tea/Cola: Y or N Amount: _____
Alcohol: Y or N Amount: _____ Daily Exercise: Y or N Amount: _____

MEDICATIONS: List dose or # of pills per day Non Prescription (Vitamins; Herbs)
Prescription Drugs

Regular Aspirin Use: Y or N Dosage & frequency: _____
NSAID (Advil, Motrin, Ibuprofen): Y or N Dosage & frequency: _____
Cortizone Injections Past Year: Y or N Date(s) and Injection site: _____

DRUG ALLERGY: Y or N List drug(s) and type of reaction: _____

LATEX ALLERGY: Y or N

TAPE ALLERGY: Y or N

FAMILY HISTORY: Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y or N	Asthma: Y or N	Kidney Disease: Y or N
Abnormal Clotting: Y or N	Diabetes: Y or N	Tuberculosis: Y or N
Anesthesia Problems: Y or N	Heart Attack: Y or N	Other Serious Illness: Y or N
Cancer: Y or N	Hypertension: Y or N	

Please describe questions with a "Yes" answer: _____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding: Y or N	Asthma: Y or N	Hypertension: Y or N
Abnormal Clotting: Y or N	Diabetes: Y or N	Sleep Apnea: Y or N
Acid Regurgitation: Y or N	Heart Attack: Y or N	Snoring: Y or N
Anemia: Y or N	Fainting Spell: Y or N	Weight Change past 12 Mo.: Y or N
Angina: Y or N	Hepatitis: Y or N	History of Herpes: Y or N

Please describe questions with a "Yes" answer: _____

Have you ever received a transfusion? Y or N if yes, what year? _____

Have you been tested for HIV? Y or N if yes, what year? _____ Test Results: Positive or Negative

Do you wear: Contact lenses: Y or N Eye glasses: Y or N Hearing Aid: Y or N Dentures: Y or N

Surgical History: Year and Type of Procedure

Indicate the type(s) of anesthesia received in the past, list any complications/reactions you experienced.

- Local anesthesia- (complications/reactions): _____
- General anesthesia- (complications/reactions): _____
- Spinal/Epidural- (complications/reactions): _____

PATIENT SIGNATURE: _____