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# HISTORY AND PHYSICAL

NAME _____ DATE OF BIRTH _____ AGE _____
Last First MI

**SOCIAL**
SEX ❒M ❒F MARRIED ❒Y ❒N OCCUPATION: _____

**HABITS**
SMOKE ❒Y ❒N Amt: _____ COFFEE/TEA/COLA ❒Y ❒N Amt: _____
ALCOHOL ❒Y ❒N Amt: _____ DAILY EXERCISE ❒Y ❒N Amt: _____

**MEDICATIONS** **List dose or number of pills per day.**
PRESCRIPTION DRUGS NON-PRESCRIPTIONS (Vitamins, herbs, etc.)
_____ _____
_____ _____
_____ _____

REGULAR ASPRIN USE ❒Y ❒N DOSAGE & FREQUENCY _____
NSAID (Advil, Motrin, Ibuprofen) ❒Y ❒N DOSAGE & FREQUENCY _____
CORTIZONE INJECTIONS (Past year) ❒Y ❒N DATE(S) & INJECTION SITE _____
DRUG ALLERGY ❒Y ❒N TYPE OF REACTION _____
LATEX ALLERGY ❒Y ❒N TAPE ALLERGY ❒Y ❒N

**FAMILY HISTORY** **Have any blood relatives ever had the following conditions?**

| | | | | | |
|---|---|---|---|---|---|
| ABNORMAL BLEEDING | ❒Y ❒N | ASTHMA | ❒Y ❒N | KIDNEY DISEASE | ❒Y ❒N |
| ABNORMAL CLOTTING | ❒Y ❒N | DIABETES | ❒Y ❒N | TUBERCULOSIS | ❒Y ❒N |
| ANESTHESIA PROBLEMS | ❒Y ❒N | HEART ATTACK | ❒Y ❒N | OTHER SERIOUS ILLNESS | ❒Y ❒N |
| CANCER | ❒Y ❒N | HYPERTENSION | ❒Y ❒N | | |

Please describe questions with a "yes" answer.
_____

**PERSONAL HISTORY** **Have you ever had the following conditions?**

| | | | | | |
|---|---|---|---|---|---|
| ABNORMAL BLEEDING | ❒Y ❒N | ASTHMA | ❒Y ❒N | HYPERTENSION | ❒Y ❒N |
| ABNORMAL CLOTTING | ❒Y ❒N | DIABETES | ❒Y ❒N | SLEEP APNEA | ❒Y ❒N |
| ACID REGURGITATION | ❒Y ❒N | HEART ATTACK | ❒Y ❒N | SNORING | ❒Y ❒N |
| ANEMIA | ❒Y ❒N | FAINTING SPELL | ❒Y ❒N | WEIGHT CHANGE (Past 12 mos.) | ❒Y ❒N |
| ANGINA | ❒Y ❒N | HEPATITIS | ❒Y ❒N | HISTORY OF HERPES | ❒Y ❒N |

Please describe questions with a "yes" answer.
_____

HAVE YOU EVER RECEIVED A TRANSFUSION? ❒Y ❒N YEAR _____
HAVE YOU BEEN TESTED FOR HIV? ❒Y ❒N YEAR _____ RESULTS: ❒POSITIVE ❒NEGATIVE
CONTACT LENSES ❒Y ❒N EYE GLASSES ❒Y ❒N HEARING AID ❒Y ❒N DENTURES❒Y ❒N

**SURGICAL HISTORY**
YEAR TYPE OF PROCEDURE
_____ _____
_____ _____
HAVE YOU HAD: LOCAL ANESTHESIA ❒Y ❒N GENERAL ANESTHESIA ❒Y ❒N SPINAL/EPIDURAL ❒Y ❒N
LIST ANY COMPLICATIONS/REACTIONS YOU EXPERIENCED TO ANY/ALL ANESTHESIA.
_____

**PATIENT SIGNATURE** _____ **DATE** _____/_____/_____