

PATIENT HEALTH HISTORY

Are you in good health? _____

Have there been any changes in your general health in the last year? _____

Are you currently under the care of a doctor? _____

Are there any conditions concerning your health or family's anesthetic history that the doctor should be told? _____

Please list any medicine, drug or pills (including over the counter items such as Vitamins or Herbs) that you are taking:

Please check yes or no below:

	Yes	No		Yes	No
Damaged heart valves/ mitral valve prolapse?	?	?	Convulsions, epilepsy?	?	?
Heart murmur?	?	?	Stroke?	?	?
Rheumatic Fever?	?	?	Thyroid trouble?	?	?
Chest pain or angina?	?	?	Diabetes?	?	?
Heart attack(s)?	?	?	Kidney trouble?	?	?
Irregular heart rate?	?	?	Stomach ulcers?	?	?
Cardiac pacemaker?	?	?	Swollen ankles, arthritis or joint disease?	?	?
Heart surgery?	?	?	AIDS or HIV infection?	?	?
Bronchitis, chronic cough?	?	?	Problems of the immune system?	?	?
Asthma?	?	?	Mental health problems?	?	?
Difficulty breathing?	?	?	Contact lenses?	?	?
Any other lung trouble?	?	?	Eye disease/glaucoma?	?	?
Do you smoke?	?	?	X-ray treatment/chemotherapy?	?	?
Blood disorder such as anemia?	?	?	Pain & clicking of jaws?	?	?
Bruise easily?	?	?	Malignant Hypothermia?	?	?
Bleeding tendency (abnormal bleed)?	?	?	Artificial body parts?	?	?
Jaundice, hepatitis or liver disease?	?	?	Are you pregnant?	?	?
High blood pressure?	?	?	Is there a chance you may be pregnant?	?	?
Low blood pressure?	?	?	Are you taking birth control pills?	?	?
ALLERGIES:			WOMEN NOTE: Antibiotics and some pain medications Alter the effectiveness of birth control pills. Consult your Physician/gynecologist for assistance regarding additional methods of birth control		
Are you allergic to or had a reaction to the following?					
Local Anesthetics? (novacain)	?	?	Are you nursing?	?	?
Penicillin?	?	?			
Other Antibiotics?	?	?			
Codeine or other narcotics?	?	?			
Other medications?	?	?			
Other allergies (latex, iodine, tape)?	?	?			

I certify that I have read and understand the above questions. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____

Date _____