

HEALTH QUESTIONS

PATIENT NAME _____ HEIGHT _____ WEIGHT _____ DATE _____

MEDICAL HISTORY

Please check the appropriate box if you have or have had any of the following:

CARDIAC: No significant history

- High Blood Pressure Chest Pain Shortness of Breath Dizziness Fainting Pacemaker Murmurs
 Abnormal heart rhythm Valve Disorder Increased Cholesterol Other _____

PULMONARY: No significant history

- Spitting up Blood Asthma Shortness of Breath Recent Upper Respiratory Infection Wheezing Sleep Apnea
 Pneumonia COPD/Emphysema Other _____

NEURO-MUSC-ORTHO: No significant history

- Cramps Numbness Joint Pain/Swelling Tingling Spasms Muscular Weakness Stiffness Seizures
 Stroke/ TIA Rheumatoid Arthritis Other: _____

GI: No significant history

- Diarrhea Ulcer Reflux Nausea Vomiting Hemorrhoids Constipation Blood in Stool Other _____

GU: No significant history

- Frequency Incontinence Discharge Urgency Discomfort Blood in Urine Stones Dribbling Recent UTI
 Abnormal Vaginal Bleeding Kidney Stone Other _____

SKIN: No significant history

- Rashes Lesions Bruising Delayed Healing Non-Healing Sores Psoriasis Mole Changes Other _____

ENDOCRINE: No significant history

- Diabetes/Type _____ Frequency of Checks _____ Usual Blood Glucose Range _____
 Hyperthyroid Hypothyroid Other _____

HEMATOLOGY/IMMUNE: No significant history

- Steroid Use Cancer -what type? _____ If Breast Cancer : Lt _____ Rt _____ Bilateral _____
 Anemia Sickle Cell Bleeding Disorder Autoimmune Disorder HIV/AIDS Hepatitis Gout Organ Transplant
 Other _____

MENTAL HEALTH: No significant history

- Depression Eating Disorder (Anorexia/Bulimia) Post-Traumatic Stress Anxiety Disorder Other _____

PAST SURGICAL HISTORY

List previous operations and dates

ANY PROBLEMS WITH SURGERY OR ANESTHESIA? _____

Bleeding/Transfusions: Have you ever had a blood transfusion? _____

MEDICATIONS

Please list any medications you are currently taking, including aspirin, birth control pills and herbal remedies

ALLERGIES Have you ever had an adverse reaction to medication, drugs, or local anesthetics? _____ If so, please list:

Have you taken aspirin-containing drugs in the past two weeks? _____

Have you ever had a reaction to Latex, Betadine, or surgical tape? _____ If yes, please list _____

If female, date of your last menstrual period _____

SOCIAL HISTORY

Do you smoke? _____ If yes, packs per day _____

Do you drink alcohol? _____ Never Occasionally Regularly Amount per day _____

Do you take recreational drugs, such as marijuana or cocaine? _____ If yes, list drugs _____

FAMILY HISTORY (Indicate relationship: F/Father M/Mother S/Sibling C/Child G/Grandparents)

- Anesthesia Problems _____ Diabetes _____ Cancer-what type? _____ High Blood Pressure _____
- Stroke _____ Heart Problems _____ Kidney Problems _____ Arthritis _____ TB _____
- Allergies _____ Seizures _____ Anemia _____ Blood/Bleeding Disorders _____ Depression _____
- Mental Illness _____ Crohn's Disease _____ Polyps _____ Other _____

PHOTO CONSENT

"I hereby grant permission for photographs to be taken, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures."

Name: _____ Date: _____