HEALTH HISTORY

(Office Use) Account: _____ Date: _____

Patient Name: _____

CONFIDENTIAL INFORMATION

PATIENT HEALTH HISTORY	YES	NO
1. Cancer		
2. Diabetes		
3. Heart Disease		
4. Heart Attack		
5. Rheumatic Fever		
6. Congenital		
7. High Blood Pressure		
8. Palpitations/Flutter		
9. Pacemaker		
10. Respiratory Disease		
11. Chronic Cough		
12. Hay Fever		
13. Shortness of Breath		
14. Asthma		
15. Positive TB Test		
16. Seizures/Strokes		
17. Loss of Consciousness		
18. Bleeding Tendency		
19. Digestive Disease		
20. Colitis		
21. Stomach Ulcers		
22. Hiatal Hernia / Reflux		
23. Liver Disease		
24. Genital / Urinary		
25. Kidney Disease		
26. Difficulty Voiding		
27. Menstrual Difficulties		
28. Sexual Dysfunction		
29. Arthritis		
30. Goiter/Thyroid Disease		
31. Migraine Headache		
32. Mental Illness		
33. Depression		
34. Nervous Breakdown		

CONFIDENTIAL INFORMATION

ALLERGIES	YES	NO
Latex Rubber		
Shellfish		
X-Ray Dye		
(Drug or Other list below)		

FAMILY HISTORY			Age	ILLNESS OR CAUSE OF DEATH
Father				
Mother				
Brothers/Sisters	**M**	**F**		
Husband/Wife				
Sons/Daughters	**M**	**F**		

HEALTH HISTORY	YES	NO	Description
Previous Hospitalization			
Previous Surgery(ies)			
Serious Illness			
Serious Injury(ies)			
History of Problems with Anesthesia:			
Self			
Family			
Steroids			
Transfusion Reaction			
Pregnant			

Comments

PERSONAL HABITS	YES	NO	PERSONAL HABITS
Have you ever smoked?			
Do you currently use tobacco?			[ ] Cigarettes [ ] Pipe [ ] Cigars [ ] Dip / Chew For how many years? ____ How many? _____
Former Smoker?			How long? ____ When quit? _____
Do you usually drink over 6 cups of coffee per day?			
Do you regularly drink alcohol?			[ ] 1 oz per day [ ] 2 oz. per day [ ] 4 oz. per day [ ] 6 oz. per day Beer: [ ] 1 bottle per day [ ] 2 bottles per day [ ] over 4 bottles per day
Do you have difficulty in falling asleep?			If yes, how often?
Do you exercise regularly?			
Are you Claustrophobic?			