



Patient History Form

Date _____

General Information

Last name		First name	MI	If child, parent's name
Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital status	Occupation	
Responsible adult available to assist during recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship		

Habits

Indicate which of the following is used, the dosage strength and frequency of use

	Amount
Smoke cigarettes: <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Drink alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Drink coffee/tea/cola: <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Exercise regularly: <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Medications

List all medications you are currently taking and the dosage strength of each

List all non-prescription drugs you are currently taking (e.g., vitamins, herbs, etc.)

Indicate which of the following is used, the dosage strength and frequency of use

	Dosage/Frequency of Use
Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
NSA (Advil, Motrin, Ibuprofen) <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cortisone injection(s), past year <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

In the space provided, list all known drug allergies and the type of reaction to each

Have you ever had an allergic reaction to the following:

Latex allergy: Yes No

Tape allergy: Yes No

Family History

Have any blood relatives ever had the following problems:

Abnormal bleeding: <input type="checkbox"/> Yes <input type="checkbox"/> No	Coronary surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease: <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal clotting: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis: <input type="checkbox"/> Yes <input type="checkbox"/> No
Anesthetic problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other serious illness: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please describe all "yes" answers:

Personal History

Have you ever had:

Abnormal bleeding: Yes No
Abnormal clotting: Yes No
Acid regurgitation: Yes No
Anemia: Yes No
Angina: Yes No
Asthma: Yes No

Cancer: Yes No
Diabetes: Yes No
Fainting spells: Yes No
Heart attack: Yes No
Hepatitis: Yes No
Hypertension: Yes No

Sleep apnea: Yes No
Snoring: Yes No
Weight change (last: Yes No
Other serious illness: Yes No

Please describe all "yes" answers:

Please answer the following questions

Have you ever received a transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what year?
Have you ever been tested for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what year? <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Do you wear contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear eye glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear a hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear dentures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what year? For:

Indicate the type(s) of anesthesia received in the past. List any complications or reactions you experienced in the column provided.

Type of Anesthesia	Complications/Reactions
Local	
General	
Spinal/Epidural	

For Women Only

Please answer the following questions

Number of pregnancies?
Number of children?
LMP?
Did you breast feed? Yes No

Signature of patient (parent or guardian)

Date