

PLEASE CHECK

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YES NO

1. Who is your family physician? _____ Are you under his treatment?
If so, for what? _____
2. Have you had a complete physical within the past year?
3. Are you now or have you within the past year been taking any pills or medicine?
If so, what? _____
4. Do you have any allergies or are you sensitive to any drug or medicine?
Please specify _____
5. Is there any family history of problems during anesthesia?
If so, what? _____
6. Do you bruise easily or bleed longer than normal for a cut or surgery?
7. Do you have any disease, or have you had a transplant operation that may suppress your immune system?
If so, please elaborate. _____
8. Have you had any of the following? Please check YES or NO

- | Yes No | Yes No | Yes No | Yes No |
|--|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Fainting Spells or Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pains | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Jaundice | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> <input type="checkbox"/> Lung Disease | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Artificial Joint |
| | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Nervous | |

9. Have you had any other serious illnesses or conditions requiring a physician's care or hospitalization?
If so, please list _____
10. Do you cough frequently? (repeatedly during the day)
11. Do you smoke? How many packs per day? _____
12. Do you require any extra pillows when you recline or sleep?
13. Have you ever had radiation or X-ray therapy?
14. Have you experienced any unfavorable reaction from a local or general anesthetic?
Please explain _____
15. Are you pregnant?
OB-GYN Problems?
16. Do you take tranquilizers or other nerve medication?
17. Do you take recreational drugs?
18. Do you wear contact lenses?
19. Do you take medicine for osteoporosis?
20. What is Your Height _____ and Weight _____ ?

<p>I AFFIRM THAT THE ABOVE MEDICAL HISTORY IS CORRECT. _____</p> <p style="text-align: center; font-size: small;">SIGNATURE OF PATIENT OR LEGAL GUARDIAN</p> <p style="text-align: right; font-size: small;">DATE</p>

History Reviewed _____

