# HEALTH HISTORY (Please Print)

**Since your well-being is our primary concern, please take the time to accurately answer the questions.**

**Name** _____ **Age** _____ **Sex** ☐**M** ☐**F**

**First** **Middle** **Last**

**Reason for visit** _____

**Your current physical health is** ☐**Good** ☐**Fair** ☐**Poor** **Height** _____ **Weight** _____

**Are you currently under the care of Physician?** ☐**Yes** ☐**No** **Date of last visit** _____

**If yes for what** _____

**Do you have any allergies?** _____

**Are you allergic to (please check)** ☐**Penicillin** ☐**Sulfa** ☐**Clindamycin** ☐**Tetracycline** ☐**Codeine** ☐**Morphine** ☐**Ibuprofen** ☐**Aspirin** ☐**Eggs or Soy** ☐**Shellfish** ☐**Latex** ☐**Tape**

**Have you ever had any problems with Local Anesthesia?** ☐**Yes** ☐**No** **Type of Reaction** _____

**Have you ever had any problems with General Anesthesia?** ☐**Yes** ☐**No** **Type of Reaction** _____

**Do you or a family member have a history of Malignant Hyperthermia?** ☐**Yes** ☐**No**

**Are you taking any medications, drugs or pills (birth control / blood thinners / aspirin / herbs / bisphosphonates)?**

☐**Yes** ☐**No List** _____

**Have your ever taken cortisone / prednisone or other steroid drugs longer than 2 weeks?** ☐**Yes** ☐**No**

**Have you had any Operations or been Hospitalized?** ☐**Yes** ☐**No**

**List**_____

_____

**Have you had or do you currently have any of the following problems? (Check Yes or No for each one)**

| Y N | Y N | Y N | Y N |
|---|---|---|---|
| ☐☐ Blood Clots | ☐☐ Abnormal Bleeding | ☐☐ Anemia | ☐☐ Sickle Cell |
| ☐☐ Snoring | ☐☐ Ulcer | ☐☐ Cancer | ☐☐ Depression |
| ☐☐ Chemotherapy Treatment | ☐☐ Sleep Apnea | ☐☐ Pancreatitis | ☐☐ HIV + / AIDS |
| ☐☐ Dizziness | ☐☐ Emphysema | ☐☐ Liver Disease/Hepatitis | ☐☐Thyroid Problems |
| ☐☐ Fainting | ☐☐ Tuberculosis | ☐☐ Bladder Problems | ☐☐ Heart Stent |
| ☐☐ Heart Failure | ☐☐ Chest Pain / Angina | ☐☐ Kidney Disease | ☐☐ Diabetes |
| ☐☐ Hay Fever | ☐☐ Heart Attack | ☐☐ Dialysis | ☐☐ Pacemaker |
| ☐☐ Sinus Problems | ☐☐ Heart Murmur | ☐☐ Organ Transplants | ☐☐ Osteoporosis |
| ☐☐ Contact Lenses | ☐☐ Artificial Heart Valves | ☐☐ Arthritis | ☐☐ Irregular Heartbeat |
| ☐☐TMJ Pain (Jaw Joint Pain) | ☐☐ Rheumatic Fever | ☐☐ Artificial Joints | ☐☐ Glaucoma |

**Are there any conditions / problems not listed above you think the doctor should know about?** ☐**Yes** ☐**No**

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**Do you now use or did you ever use tobacco?** ☐**Yes** ☐**No (**☐**Chew** ☐**Smoke) Packs per day**___ **Years**_____ **Stopped**___

**Do you now or did you ever drink alcohol?** ☐**Yes** ☐**No** **Amount**_____ **Date Stopped**_____

**Do you use recreational drugs?** ☐**Yes** ☐**No** **Type**_____

**<u>Women</u> Are you or could you be pregnant?** ☐**Yes** ☐**No** **Are you nursing?** ☐**Yes** ☐**No**

_____

**I hereby certify that the answers I have given to the above questions are true & correct to the best of my knowledge. I will not hold my surgeon or any member of their staff, responsible for errors or omissions that I may have made in the completion of this form.**

**Date** _____ **Signature**_____