



Patient Health History

Last Name First Name Middle Initial

Date of Birth Age

Occupation Weight

Name of physician requesting this consultation

Past History

Please list any prior major illnesses, chronic diseases, syndromes, or conditions and/or injuries:

Surgeries/Hospitalizations None Year Complications

Have you ever had problems with anesthesia? Yes No

Current Medication(s), None including aspirin Dose Frequency

List any allergies/reactions to medications, anesthetics or materials: None

Family History:

Do you have a family history of trouble with anesthesia? Yes No

Do you have a family history of easy bleeding? Yes No

Social History:

Do you smoke?

- No, I have never smoked.
- Yes, I smoke ____ packs of cigarettes per day for ____ years.
- No, I quit ____ years ago. At the most I've smoked ____ packs per day for ____ years.
- Yes, I smoke cigars or a pipe.
- Chewing tobacco? ____ Can(s) per _____
- Exposed to second-hand smoke?

Do you drink alcohol?

- No, never (or rarely)
- No, but I used to. How much? _____
- Yes Daily 1 or more times a week 1 or more times a month. How much? _____

Review of Systems

Are you currently, or have you had problems with:

Constitutional

- Weight gain Yes No
- Weight loss Yes No
- Night sweats Yes No
- Insomnia Yes No

Eyes

- Double vision Yes No
- Visual loss Yes No

Ear, Nose, Throat and Mouth

- Hearing loss Yes No
- Noise/ringing in ears Yes No
- Nasal congestion Yes No
- Sore throat Yes No
- Trouble swallowing Yes No
- Hoarseness Yes No

Cardiovascular

- Chest pain or angina Yes No
- Heart trouble Yes No
- Rheumatic fever Yes No
- Heart murmur Yes No
- High blood pressure Yes No

Neurological

- Numbness Yes No
- Weakness Yes No
- Stroke Yes No
- Headache Yes No

Allergic/Immunologic

- Sneezing Yes No
- Itchy eyes/nose Yes No
- Itchy throat Yes No
- Skin rash Yes No
- HIV Yes No

Respiratory

- Asthma Yes No
- Coughing up blood Yes No
- TB Yes No
- Pneumonia Yes No
- Snoring Yes No
- Trouble breathing at night Yes No

Gastrointestinal

- Indigestion/heartburn Yes No
- Ulcer Yes No
- Hepatitis Yes No
- Jaundice (yellowing) Yes No
- Blood in stool Yes No
- Black, tarry stools Yes No

Genitourinary

- Bladder trouble Yes No
- Prostate disease Yes No
- Kidney disease Yes No

Musculoskeletal

- Arthritis Yes No

Endocrine

- Diabetes Yes No
- Thyroid disease Yes No

Hematologic

- Bleeding disorder Yes No
- Easy bleeding Yes No

Psychiatric

- Depression Yes No
- Anxiety Yes No

The above information is accurate to the best of my knowledge.

I have reviewed the above information with the patient.

Patient Name

Physician Signature

Patient Name or Guardian Signature

Date

Date