

OFFICE PROCEDURE HEALTH HISTORY

Last Name _____ First _____ MI _____ Date of Birth _____ Age _____

Has your address, contact information, insurance or pharmacy information changed since your last visit?

NO YES If yes please give details _____

RELEVANT MEDICAL INFORMATION

1. Current Height _____ and Weight _____ lbs.

2. Medical Conditions: (please check if you have any of the following)

<input type="checkbox"/> No medical problems	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> COPD	<input type="checkbox"/> Cancer
<input type="checkbox"/> Increased Cholesterol	<input type="checkbox"/> Other: _____			

3. Have you had any past surgeries? NO YES

4. Have you ever had problems with anesthesia? NO YES

If yes, please tell us what happened _____

5. Please list all past surgeries and dates below.

<u>Surgery</u>	<u>Date</u>	<u>Surgery</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Have you taken any **blood thinning products in the last 72 hrs** such as aspirin, fish oil, Vitamin E, Excedrin, Plavix, or Coumadin? NO YES

7. When was the last time you had anything to eat? _____

What did you eat? _____

8. When was the last time did you had something to drink? _____

What did you drink? _____

9. Did you take any medication(s) this morning? _____

What medication(s) did you take? _____

10. Are you allergic to any medication(s) or latex? NO YES

Please list all medications you are allergic to and type of reaction.

<u>Medication and reaction</u>	<u>Medication and reaction</u>
1. _____	3. _____
2. _____	4. _____

Patient Signature

Date

TSC3/2011LR