

History and Physical

Name: _____ Date: _____

Age: _____ Sex: M or F Married: Y or N Occupation: _____

Smoke: Y or N Amount: _____ Coffee/Tea/Cola: Y or N Amount: _____

Alcohol: Y or N Amount: _____ Daily Exercise: Y or N Amount: _____

MEDICATIONS: List dose or # of pills per day Non Prescription (Vitamins; Herbs)

Regular Aspirin Use: Y or N Dosage & frequency: _____

NSAID (Advil, Motrin, Ibuprofen): Y or N Dosage & frequency: _____

Cortizone Injections Past Year: Y or N Date(s) and Injection site: _____

DRUG ALLERGY: Y or N List drug(s) and type of reaction: _____

LATEX ALLERGY: Y or N **TAPE ALLERGY:** Y or N

FAMILY HISTORY: Have any blood relatives ever had the following problems:

| | | |
|-----------------------------|----------------------|-------------------------------|
| Abnormal Bleeding: Y or N | Asthma: Y or N | Kidney Disease: Y or N |
| Abnormal Clotting: Y or N | Diabetes: Y or N | Tuberculosis: Y or N |
| Anesthetic Problems: Y or N | Heart Attack: Y or N | Other Serious Illness: Y or N |
| Cancer: Y or N | Hypertention: Y or N | |

Please describe questions with a "Yes" answer: _____

PERSONAL PAST HISTORY: Have you ever had:

| | | |
|----------------------------|------------------------|-----------------------------------|
| Abnormal Bleeding: Y or N | Asthma: Y or N | Hypertension: Y or N |
| Abnormal Clotting: Y or N | Diabetes: Y or N | Sleep Apnea: Y or N |
| Acid Regurgitation: Y or N | Heart Attack: Y or N | Snoring: Y or N |
| Anemia: Y or N | Fainting Spell: Y or N | Weight Change past 12 Mo.: Y or N |
| Angina: Y or N | Hepatitis: Y or N | History of Herpes: Y or N |

Please describe questions with a "Yes" answer: _____

Have you ever received a transfusion? Y or N if yes, what year? _____

Have you been tested for HIV? Y or N if yes, what year? _____ Test Results: Positive or Negative

Do you wear: Contact lenses: Y or N Eye glasses: Y or N Hearing Aid: Y or N Dentures: Y or N

Surgical History: Year and Type of Procedure

Indicate the type(s) of anesthesia received in the past, list any complications/reactions you experienced.

- o Local anesthesia- (complications/reactions): _____
- o General anesthesia- (complications/reactions): _____
- o Spinal/Epidural- (complications/reactions): _____

PATIENT SIGNATURE: _____ **DATE** _____