

Health History

Patient name: _____ Weight _____

1. Are you in good health?..... Y N
2. Are you presently under the care of a physician for a chronic medical condition?..... Y N
If so for what reason? _____
3. Have you had any serious illnesses, operations or hospitalizations?..... Y N
If so please describe _____
Have you had any adverse reactions to any form of anesthesia?
4. Do you have any of the following? - please circle
 - Cardiovascular**
heart trouble heart attack heart murmur/mitral valve prolapse stroke palpitations
high blood pressure coronary artery disease heart surgery pacemaker angina
Rheumatic fever/rheumatic heart disease congenital heart disease
 - Respiratory** - please circle
asthma emphysema chronic cough bronchitis pneumonia tuberculosis
chest pain severe coughing lung surgery
 - Bleeding disorder** - please circle
Anemia bleeding tendency need for transfusions bruise easily
 - Liver disease..... Y N
 - Kidney disease..... Y N
 - Stomach ulcers, colitis..... Y N
 - Arthritis, artificial joint replacement..... Y N
 - Seizures, convulsions, epilepsy..... Y N
 - Thyroid disease..... Y N
 - Cancer..... Y N
Radiation Y N Chemotherapy Y N
 - Diabetes..... Y N
 - Glaucoma..... Y N
 - Sinus/nasal problems..... Y N
 - Psychiatric treatment..... Y N
 - Any disease, drugs or transplant operation that would depress your immune system..... Y N
 - AIDS/HIV, Hepatitis or Herpes? - please circle..... Y N
 - Please list all allergies including drugs, latex, food etc. _____
5. Please list all medications you are currently taking including prescription, non-prescription and herbal/natural supplements _____

6. Have you ever taken bisphosphonate medications (Fosomax, Zometa, Actonel, Boniva, Aredia) for osteoporosis, multiple myeloma or other cancers?..... Y N
7. Do you use alcohol? How much per day?..... Y N
8. Do you use tobacco? How much per day? _____ For how long? _____ Y N
9. Have you recently used any recreational drugs?..... Y N
10. Women: Are you pregnant, trying to become pregnant or any chance you might be pregnant?..... Y N
Are you taking birth control pills? Y N Are you breastfeeding? Y N
11. Do you have any other disease/conditions the doctor should know about? If yes please explain..... Y N

I understand the importance of an accurate health history. The above questions have been answered to the best of my knowledge.

Signed: _____ Date: _____

Reviewed by: _____ Date: _____