PLEASE COMPLETE ALL SPACES-DO NOT LEAVE ANY BLANKS

List your current physician(s) and their specialty____

HAVE YOU HAD OR DO YOU HAVE:

YES NO A Positive AIDS /HIV Blood Test
YES NO Abnormal Bleeding Tendencies
YES NO Acid Reflux
YES NO Allergy Tests
Date_______Results:_______________
YES NO Anticoagulant Therapy (blood thinner)
YES NO Arthritis
YES NO Asthma
YES NO Ever Used Asthma Medication
Last time asthma medication used:_____________
Asthma medications used:____________________
YES NO Back Trouble
YES NO Blood Disease
YES NO Blood Transfusion
YES NO Blood Vessel Disease
YES NO Bronchitis
YES NO Chest X-ray in the Past Year
YES NO Chronic Lung Disease
YES NO Dental Caps or Bridges
YES NO Diabetes
YES NO Electrocardiogram in Past Year
YES NO Emphysema
YES NO Epilepsy or Seizures
YES NO False or Loose Teeth
YES NO Fracture of Facial Bones
YES NO Spine Problems What Kind?________________
YES NO Glaucoma
YES NO Hearing Loss
YES NO Heart Trouble: What Kind?_________________
YES NO Hepatitis
YES NO High Blood Pressure
YES NO Hoarseness
YES NO Jaundice
YES NO Kidney Disease
YES NO Mononucleosis
YES NO Muscle Weakness
YES NO Paralysis
YES NO Pneumonia
YES NO Psychiatric or Mental Disorders
Circle One: Panic Attacks Depression
Describe:_____________________________________
YES NO Stroke
YES NO Thyroid Disease
YES NO Speech Problem
YES NO Seen Speech Therapy. Where?_________________

PREVIOUS ANESTHETIC HISORY:

Date of last anesthetic:___________________
Any abnormal reactions?_________________ YES NO
Relatives with abnormal reactions to Anesthetics YES NO
Comments:____
____
____

PREVIOUS SURGERY HISTORY: If YES give date of surgery

YES NO Hernia ____
YES NO Joint Surgery ___What Kind? ________________________________
YES NO Gallbladder____
YES NO Hysterectomy____
YES NO Heart Bypass ____
YES NO Angioplasty ____
YES NO Sinus Surgery ____
YES NO Nasal Surgery ____
YES NO Cosmetic Surgery ____
YES NO Tonsillectomy ____
YES NO Ear Surgery ____
YES NO Ear Tubes____
YES NO Adenoidectomy____
If any other surgeries, Please list: ____
____

CURRENT MEDICATIONS:

Prescriptions: ____
____
____

Non-Prescriptions: ____
____
____

Herbal Remedies: ____
____

ALLERGIES:

Drug:____
____
Describe the allergic reaction:__________________________________
Food or Other:____
____

IF FEMALE OF CHILDBERING AGE:

Are you pregnant? Yes No

Please list ANY Medical Problems, Hospitalizations, and/or Illnesses not listed above: NONE
____
____

Please list Any Medical Problems that run in your family: NONE
____
____

DO YOU:

Wear Contact Lenses **YES NO**
Use Tobacco **YES NO**
Drink Alcoholic Beverages **YES NO**
Use Illegal Drugs (Cocanie, Heroin, etc) **YES NO**
Object to a blood transfusion to save your life (if needed)

AGE:__________**Approx. Wieght:**______________

____
Patient's Name

____
Patient/Guardian Signature

____
Date

Physician Reviewed: ____________________

Reviewed & Updated
By:_________________Date___________Weight_________Allergies__________
By:_________________Date:___________Weight________Allergies__________
By:_________________Date____________Weight________Allergies__________
By:_________________Date:___________Weight________Allergies__________

YES NO Is there any other medical information?____