MRN:____________

PHARMACY: ______________________________

Name: ______________________________ **Date of Birth:** ______________ **Age:** _____ ☐M ☐F

Height:______ **Weight:**________ **BMI:**____________

Current Medications & Supplements

☐ NO CURRENT MEDICATIONS OR SUPPLEMENTS

MEDICATION NAME	DOSE	ROUTE	FREQUENCY
Example: Lisinopril	*10mg*	*oral*	*once/day*

Medication Allergies	Reaction
☐ NO KNOWN ALLERGIES	

All Previous Surgeries	Date

Medical History: Please check either "**YES**" or "**NO**" to EVERY item below and fill in Other information.

Heart

	YES	NO	
Heart Attack	☐	☐	______ (Year)
Heart Cath	☐	☐	______ (Year)
Bypass	☐	☐	______ (Year)
Stent(s)	☐	☐	______ (Year)
Valve Replaced	☐	☐	______ (Year)
Pacemaker	☐	☐	______ (Year)
Defibrillator/AICD	☐	☐	______ (Year)
High Blood Pressure	☐	☐	
Irregular Heartbeat	☐	☐	☐ (AFib)
High Cholesterol	☐	☐	
Heart Failure/CHF	☐	☐	

My Cardiologist: ______________

Last Visit: ______________

Endocrine/Kidney

	YES	NO	
Diabetes	☐	☐	A1C: ______
			☐ On Insulin
Thyroid Disease	☐	☐	
Liver Disease/Cirrhosis	☐	☐	
Kidney Failure	☐	☐	
On Dialysis	☐	☐	

Blood / Cancer

	YES	NO	
Blood Clot (DVT/PE)	☐	☐	______ (Year)
On a Blood Thinner	☐	☐	______ (type)
Chronic Anemia	☐	☐	
Cancer	☐	☐	______ (type)

Lungs

	YES	NO	
Emphysema/COPD	☐	☐	☐ on Oxygen
Asthma	☐	☐	______ liters
Sleep Apnea (OSA)	☐	☐	☐ Use CPAP
Chronic Bronchitis	☐	☐	
Tuberculosis (TB)	☐	☐	
Recent Respiratory Illness	☐	☐	

______________ (type) ______________

Rheumatology

	YES	NO
Rheumatoid Arthritis (RA)	☐	☐
Lupus (SLE)	☐	☐
Gout	☐	☐

Social History

	YES	NO	
Smoke	☐	☐	_____ (Packs/day)
Chew Tobacco	☐	☐	
Use Marijuana	☐	☐	
Vape	☐	☐	
Alcohol	☐	☐	_____ (Drinks/day)
Use Illegal Drugs	☐	☐	
History of Withdrawal	☐	☐	
Pain Management	☐		MD ______________

Brain

	YES	NO	
Stroke / TIA	☐	☐	______ (Year)
Seizures	☐	☐	______ (Year)
Depression	☐	☐	☐ Bipolar
Anxiety	☐	☐	
Alzheimers/Dementia	☐	☐	
Parkinsons	☐	☐	
Glaucoma	☐	☐	
Brain Implants	☐	☐	Clips, Stimulator Ear/Hearing

GI System

	YES	NO
GI Bleed	☐	☐
Ulcer	☐	☐
Acid Reflux/Heartburn	☐	☐
Hiatal Hernia	☐	☐
Crohn's/U. Colitis	☐	☐

Infections

	YES	NO	
HIV/AIDS	☐	☐	
Hepatitis B/C	☐	☐	
MRSA	☐	☐	______ (Year)
Current Infection	☐	☐	______ (type)

Additional (Other) Medical Information:______________________________

____

____

PATIENT HEALTH HISTORY

Updated 2/2/2022

OFFICE USE ONLY
BMI:________≥ 45 = ANESTHESIA CONSULT

Name: ______________________ **Age:** ________ **Date of Birth:** ____________

Last Menstrual Period: ______________ **Are You Pregnant?** ________

REVIEW OF SYSTEMS

Please check box(s) if you have experienced the following within the past 6 months

General
- ☐ Poor Appetite
- ☐ Unexplained weightloss
- ☐ Recent Fever

Head
- ☐ Frequent Headaches

Eyes
- ☐ Visual Changes

Throat
- ☐ Chronic Sore Throat
- ☐ Difficulty Swallowing

Mouth
- ☐ Recent Dental Infection

Lungs
- ☐ Shortness of Breath
- ☐ Chronic Cough

Heart
- ☐ Chest Pain
- ☐ Pounding of Heart
- ☐ Chronic Leg Swelling

Abdomen
- ☐ Nausea/Vomiting
- ☐ Bowel Irregularities
- ☐ Blood in Stools
- ☐ Recurrent Indigestion
- ☐ Abdominal Pain

Urinary
- ☐ Urinating at Night
- ☐ Frequent Urination
- ☐ Painful/Burning Urination

Blood
- ☐ Bruise Easily
- ☐ Bleed Easily

Skin
- ☐ Infection
- ☐ Ulcer/Wound

Other ____________________

____

____

Anesthesia History:

- ☐ Life threatening/Severe reaction to Anesthesia
  Explain:____________________
- ☐ History of Difficult Intubation (breathing tube)
  Explain:____________________
- ☐ History of Malignant Hyperthermia: ☐ Yes ☐ No ☐ Self ☐ Family
  Explain:____________________
- ☐ Significant Nausea or Vomiting after Anesthesia
- ☐ Severe Motion Sickness
- ☐ Dental: Loose or Capped Teeth

Allergies:

- ☐ Allergy to certain Anesthetics (gas, IV, Local ie: "caines")
  Explain:____________________
- ☐ Allergy to Metal : ☐ Yes ☐ No
- ☐ Allergy to Latex: Reaction: ☐ Swelling/Breathing ☐ Rash
- ☐ Allergy to Adhesives/ Tape: Reaction:____________________
- ☐ Allergy to Food(s): List:____________________
  ____
- ☐ Eggs: Reaction:____________________

Other:

- ☐ History of Chronic Pain/Daily Narcotics
- ☐ Contact Lenses ☐ Hearing Aids ☐ Piercings
- ☐ Implanted Hardware/Metal or Devices: Explain: ____________________
  ____
- ☐ Cortisone (steroid) use in last year: ☐ Pills ☐ Injection
- ☐ History of a Blood Transfusion: Reaction: ☐ Yes ☐ No
  Explain:____________________

Family History:

- ☐ Blood Clots
- ☐ Heart Attack/Disease
- ☐ Cancer:______________
- ☐ Diabetes
- ☐ Lung Disease
- ☐ Bleeding Disorders
- ☐ Liver Disease
- ☐ Kidney Disease

Date: ____________ Patient Signature: ________________ MA Signature: ________________

Updated: ____________ Patient Signature: ________________ MA Signature: ________________

PATIENT HEALTH HISTORY

Updated 2/2/2022