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PATIENT HEALTH HISTORY

NAME: _____ AGE: _____ DATE OF BIRTH: _____

MEDICATIONS: List all medications and dosages (prescription and over the counter)

Medication:	Dosage:	Reason For Use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES? No ___ Yes ___ LIST: _____

If yes, what type of reaction do you have? _____

FAMILY DOCTOR: _____ **Phone:** _____

HEALTH HISTORY:

Height: _____ Weight: _____

Smoker? No ___ Yes ___ How much? _____ Former Smoker? _____ How Many Years ? _____

Nicotine Products: _____

Alcohol Use? No ___ Yes ___ How Much? _____

Has any member of your family been told to alert anesthesia providers of problems with high fever due to a reaction to anesthesia or sensitivity to muscle relaxants? No ___ Yes ___

Have you ever had a reaction to anesthesia? (Slow to wake up, nausea, etc.) No ___ Yes ___

Do you have chest pain/shortness of breath with walking or exercise? No ___ Yes ___

Past Illnesses or Disorders: (Circle if Yes)

- Brain (stroke, epilepsy, etc.)
- Nervous system (paralysis, numbness, tingling, etc.)
- Eyes (glaucoma, dryness, etc.)
- Ears (ear drum rupture, etc.)
- Face (paralysis, retrusive chin, difficulty opening jaws)
- Nose, Sinuses, Throat (frequent infections, etc.)
- Breast (fibro-cystic disease, tumors, etc.)
- Heart/Blood Vessels (Rheumatic fever, irregular heartbeat, high blood pressure, heart attack, etc.)
- Stomach (Hiatal Hernia, Ulcer, Heartburn, etc.)
- Intestines (spastic colon, ulcers, obstructions, etc.)
- Blood (anemia, bleeding disorders, HIV, etc.)
- Bladder/Kidney (frequent infections, stones, prostate, etc.)
- Reproductive (ovarian cysts, fibroids, ectopic pregnancies, etc.)
- Arms/Legs (peripheral vascular disease, history of phlebitis or blood clots, abnormalities, etc.)
- Bones/Joints (Polio, MS, MD, Arthritis, Stiff Neck, etc.)
- Endocrine (Diabetes, Thyroid – hyper or hypo, etc.)
- Skin (allergy to adhesive, frequent rashes, eczema, etc.)
- Mental Health (hospitalizations, significant emotional problems, etc.)
- Sleep Apnea Use of CPAP Machine? _____ Sleep Studies _____

Additional Information?

PREVIOUS SURGERY:

Operation	Month/Year	Location (Hospital/City)	Surgeon	Anesthesia Type

The information I have provided is accurate and complete to the best of my knowledge. I realize the information I provide will influence the care given to me by my surgeon William M. Davis, M.D. as well as other professionals participating in my surgical procedure and this information will be shared with these other professionals during this surgery procedure.

Signature: _____ **Date:** _____