Patient Health History Form

rev 09/08

Patient Name: ______________________________ **DOB**:_____/_____/_____ **Date of Visit**:_____/_____/_____

Chief Complaint:____

MEDICATIONS: (please list all current medications including vitamins and over the counter meds)

ALLERGIC TO: (please list all medications, anesthetics, materials or food)

CURRENT MEDICAL CONDITIONS: (please list all current medical conditions, i.e. diabetes, high blood pressure)

PAST MEDICAL HISTORY: (please list all prior medical conditions)

SURGERIES/HOSPITALIZATIONS:

1. ________________________________

2. ________________________________

3. ________________________________

4. ________________________________

SOCIAL HISTORY: (MUST circle Yes or No)

Do you smoke? Y N In the past?_______________

Do you drink alcohol? Y N How much?_______________

Do you work? Y N Occupation____________________

Marital Status: S M D W

Do you *currently* suffer from any of the following symptoms or problems? (MUST circle Yes or No)

Hearing Loss	**Yes/No**	Sneezing	**Yes/No**	Arthritis	**Yes/No**
Noise/ringing in ears	**Yes/No**	Dizziness	**Yes/No**	Bruising	**Yes/No**
Nasal Congestion	**Yes/No**	Skin Rash	**Yes/No**	Sleep Disturbance	**Yes/No**
Nasal Drainage	**Yes/No**	Weight Loss/Gain	**Yes/No**	Diabetes	**Yes/No**
Sore Throat	**Yes/No**	Thyroid Disease	**Yes/No**	Cancer	**Yes/No**
Trouble Swallowing	**Yes/No**	Weakness	**Yes/No**	Seizures	**Yes/No**
Hoarseness	**Yes/No**	Numbness	**Yes/No**	Fatigue	**Yes/No**
Chest Pain/Angina	**Yes/No**	Shortness of Breath	**Yes/No**	Heartburn	**Yes/No**
Depression	**Yes/No**	High Blood Pressure	**Yes/No**	Snoring	**Yes/No**

Do you or anyone in your family have difficulty with anesthesia? Yes/No If Yes, who________________

Do you or anyone in your family have a history of bleeding easily? Yes/No If Yes, who________________

Patient (Guardian) Signature: ____Date: _____/_____/_____

Physician's Signature: ____Date: _____/_____/_____