

NAME: _____ DATE: _____

PERSONAL PAST HISTORY - Have you ever had the following: (please check Yes or No)

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Abnormal Bleeding	___	___	Asthma	___	___	Hypertension	___	___
Abnormal Clotting	___	___	Diabetes	___	___	Sleep Apnea	___	___
Acid Regurgitation	___	___	Fainting Spell	___	___	Snoring	___	___
Anemia	___	___	Heart Attack	___	___	Weight Change past 12 mos	___	___
Angina	___	___	Hepatitis	___	___	Other Serious Illness	___	___
Staph Infection	___	___	M.R.S.A.	___	___	Latex Allergies	___	___

Please describe Other Serious Illness and any questions with "Yes" answer: _____

Have you ever received a transfusion? Yes ___ No ___ If yes, what year? _____

Have you ever been tested for HIV? Yes ___ No ___ If yes, what year? _____ Test Results: __Positive __Negative

Do you wear any of the following:

Contact Lenses? ___Yes ___No Eye Glasses? ___Yes ___No Hearing Aid? ___Yes ___No Dentures ___Yes ___No

Previous Surgery (Please provide year & type of procedure): _____

Indicate the type(s) of anesthesia received in the past, list any complications or reactions you experienced:

___ Local Anesthesia - complications / reactions _____

___ General Anesthesia - complications / reactions _____

___ Monitored Anesthesia care - complications / reactions _____

___ Spinal / Epidural - complications / reactions _____

Date last seen by Primary Care Physician: _____ Primary Care Physician Name: _____

Primary Care Physician Address: _____ Phone #: () _____

Have you ever been seen by a cardiologist? ___Yes ___No If yes, Cardiologist Name: _____

Cardiologist Phone # () _____

SOCIAL HISTORY

Age: _____ Sex: ___M ___F Married: ___Y ___N Occupation: _____

Responsible adult available to assist during recovery period: ___Y ___N Relationship: _____

Smoke: ___Y ___N Amount: _____ Coffee/Tea/Cola: ___Y ___N Amount: _____

Alcohol: ___Y ___N Amount: _____ Daily Exercise: ___Y ___N Amount: _____

FAMILY HISTORY - Have any blood relatives ever had the following problems:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Abnormal Bleeding	___	___	Coronary Surgery	___	___	Kidney Disease	___	___
Abnormal Clotting	___	___	Diabetes	___	___	Tuberculosis	___	___
Anesthetic Problems	___	___	Heart Attack	___	___	Cancer	___	___
Hypertension	___	___	Stroke	___	___	Other Serious Illness	___	___

Please describe questions with a "Yes" answer: _____

REVIEW OF SYSTEMS ----- BELOW TO BE COMPLETED BY PHYSICIAN ONLY

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Loose Dental Devices	___	___	Recent Up Resp Infection	___	___	Vomiting	___	___
Neck Mobility Prob.	___	___	Normal Menstrual Cycle	___	___	Difficulty Voiding	___	___
Short Neck	___	___	Stroke	___	___	Seizure	___	___
Cough	___	___	Chest Pain	___	___	Current Pregnancy	___	___
Shortness of Breath	___	___	Irregular Heart Beat	___	___	Black Out	___	___
Obesity	___	___	Height _____	Weight _____	Hosp _____	ASF _____		

Comments: _____