history and physical

Name: _____ Date: _____

social:

Age: _____ **Sex**: ☐ M ☐ F **Married**: ☐ Yes ☐ No **Occupation**: _____

Responsible adult available to assist during recovery period: ☐ Yes ☐ No **Relationship**: _____

habits:

☐ **Smoke**, Amount _____ ☐ **Coffee/Tea/Cola**, Amount _____

☐ **Alcohol**, Amount _____ ☐ **Daily Exercise**, Amount _____

medications:

List dose or number of pills per day

Prescription Drugs

_____

_____

_____

_____

Non Prescription (Vitamins; Herbs)

_____

_____

_____

_____

☐ **Regular Aspirin Use**, Dosage & frequency _____

☐ **NSA (Advil, Motrin, Ibuprofen)**, Dosage & frequency _____

☐ **Cortisone Injections Past Year**, Date(s) and injection location _____

☐ **Drug Allergy**, List drug(s) and type of reaction _____

_____

☐ **Latex Allergy** ☐ **Tape Allergy**

family history:

Have any blood relatives ever had the following problems:

☐ Abnormal Bleeding ☐ Diabetes ☐ Cancer ☐ Tuberculosis

☐ Coronary Surgery ☐ Anesthetic Problems ☐ Hypertension ☐ Other Serious Illness

☐ Abnormal Clotting ☐ Heart Attack ☐ Kidney Disease

Please describe questions with a checkmark _____

_____

women patients only:

Number of pregnancies ____ Number of children ____ Last menstrual period ____ ☐ Did you breast feed?

Bra size _____ Last MMG _____ Results _____ Additional breast studies _____

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personal past history:

Have you ever had:

- ☐ Abnormal Bleeding
- ☐ Abnormal Clotting
- ☐ Acid Regurgitation
- ☐ Anemia
- ☐ Angina
- ☐ Asthma
- ☐ Diabetes
- ☐ Fainting Spell
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Weight Change past 12 months
- ☐ Other Serious illness

Please describe questions with a checkmark _____

_____

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

Have you been tested for HIV? ☐ Yes ☐ No **If yes, what year**? _____ **Result**: ☐ Positive ☐ Negative

Do you wear:

- ☐ Contact lenses
- ☐ Eye glasses
- ☐ Hearing aid
- ☐ Dentures

Previous Surgery, year and type of procedure _____

_____

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

- ☐ **Local anesthesia** - (complications/reactions): _____
- ☐ **General anesthesia** - (complications/reactions): _____
- ☐ **Spinal / Epidural** - (complications/reactions): _____

Date last seen by Primary Care Physician _____ **Primary Care Physician** (name) _____

Telephone (____) _____ Address _____

review of systems:

- ☐ Loose Dental Devices
- ☐ Chest Pain
- ☐ Neck Mobility Problem
- ☐ Irregular Heart Beat
- ☐ Short Neck
- ☐ Vomiting
- ☐ Cough
- ☐ Difficult Voiding
- ☐ Shortness of Breath
- ☐ Seizure
- ☐ Recent Upper Respiratory Infection
- ☐ Current Pregnancy
- ☐ Normal Menstrual Period
- ☐ Black Out
- ☐ Stroke
- ☐ Obesity

Additional Form Comments:

_____

_____

_____

_____

Height _____ **Weight** _____ **Blood Pressure** _____ **Pulse** _____