

MEDICAL HISTORY

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| 1. | Do you have any general health problems?
If so, please specify _____ | Y | N |
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| 2. | Are you now under a physician's care or have you been during the past 5 years, including hospitalization(s) and surgery? | Y | N |
| 3. | Name of physician _____
Address: _____
Phone number: _____ | | |
| 4. | Are you currently under a doctor's orders or taking any medication(s), including any birth control pills, over-the-counter drugs, herbal supplements or homeopathic preparations? | Y | N |
| 5. | Do you have any allergies or are you sensitive to any drugs or substances such as penicillin, novacaine, aspirin, latex, or codeine? _____ | Y | N |
| 6. | Have you ever bled excessively after a cut, wound, or surgery? Have you ever received a blood transfusion? | Y | N |
| 7. | Are you subject to fainting, dizziness, nervous disorders, seizures, or epilepsy? | Y | N |
| 8. | Have you ever had any breathing difficulty, including asthma, emphysema, chronic cough, pneumonia, TB, or any other lung disorder? Do you snore or have you been diagnosed with sleep apnea? Do you use tobacco products? | Y | N |
| 9. | Have you or your family members ever had any anesthesia-related problems? | Y | N |
| 10. | Do you have heart disease or a history of chest pain or palpitations? | Y | N |
| 11. | Are you or might you be pregnant? | Y | N |
| 12. | Do you currently use or have a history of using recreational drugs? | Y | N |
| 13. | Is there anything you would like to discuss alone with the doctor? | Y | N |

Patient signature	Date
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Dr. signature	Date
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