

Name: _____
 Last Name **First Name** **Middle**

Birth date: _____ **Height** _____ **Weight** _____

General Health: *excellent* *good* *fair* *poor*

If not "good", please explain _____

Have you had any previous surgeries? Yes ___ No ___
If yes, list: **Doctors Name** **Operation** **Date**

Have you had any after effects from previous surgery? Yes ___ No ___
If yes, please specify _____

Have you or any relative had:

- | | | | |
|----------------|------------------------------|-----------------------------|-----------------------------------|
| Tuberculosis | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Relative <input type="checkbox"/> |
| Epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Relative <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Relative <input type="checkbox"/> |
| Heart Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Relative <input type="checkbox"/> |
| Kidney Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Relative <input type="checkbox"/> |
| Blood Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Relative <input type="checkbox"/> |
| Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Relative <input type="checkbox"/> |
| Mental Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Relative <input type="checkbox"/> |
| Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Relative <input type="checkbox"/> |

Medications / Drugs:

What is your approximate daily consumption of the following:

- Aspirin* _____
- Tobacco* _____
- Coffee/Tea* _____
- Alcohol* _____

Please list all medications you are now taking including *birth control pills, diuretics, analgesics, blood pressure or heart medications, tranquilizers, hormones, blood thinners:*

Primary Care Physician _____ **Phone** _____

-
- Have you ever had a bad reaction to general anesthetic? No__ Yes__
- Has any member of you family had a reaction t general anesthetic? No__ Yes__
- Have you required unusually large amounts of local anesthetic for medical or dental purposes? No__ Yes__
- Have you ever had a bad reaction to a local anesthetic? No__ Yes__
- Do you bleed or bruise easily? No__ Yes__
- Have you ever required a blood transfusion? No__ Yes__
- Are you in a high risk category for HIV? No__ Yes__
- Have you ever been tested for HIV? No__ Yes__
- Do you have high blood pressure? No__ Yes__
- Have you ever had Scarlet Fever or Rheumatic Fever? No__ Yes__
- Have you ever had Hepatitis? No__ Yes__
- Do you form large scars or Keloids? No__ Yes__
- Do you have any skin disease, hives, eczema or rash? No__ Yes__
- Do you have frequent infections or boils? No__ Yes__
- Have you taken steroid medications, cortisones or ACTH? No__ Yes__
- Do you have shortness of breath while walking? No__ Yes__
- Do you have or have you had any significant emotional problems? No__ Yes__
- Are you pregnant? No__ Yes__
- Are you a survivor of chemical, sexual or alcohol abuse? No__ Yes__
- Are you allergic to any medications or adhesive tape? No__ Yes__

If yes, which one(s)? _____

What kind of reaction? _____

Have you had illnesses of the following: (Circle if yes)

- | | | | | | |
|---------------|--------------|--------------|-------------------|-------------|-----------------------|
| <i>Kidney</i> | <i>lungs</i> | <i>Chest</i> | <i>Stomach</i> | <i>Arms</i> | <i>Nervous System</i> |
| <i>Throat</i> | <i>Nose</i> | <i>Eyes</i> | <i>Bladder</i> | <i>Neck</i> | <i>Hiatal Hernia</i> |
| <i>Brain</i> | <i>Heart</i> | <i>Ears</i> | <i>Intestines</i> | <i>Legs</i> | |

Date

Signature of patient or guardian