

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	No	Relative
Epilepsy	Yes	No	Relative
Diabetes	Yes	No	Relative
Heart Disease	Yes	No	Relative
Kidney Disease	Yes	No	Relative
Blood Disease	Yes	No	Relative
Asthma	Yes	No	Relative
Mental Disease	Yes	No	Relative
Cancer	Yes	No	Relative

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:*

-
- 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