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## History and Physical

Name: ____________________________________________ Date: __________

Previous Surgery, year and type of procedure: _______________________________________
_____________________________________________________________________________

**PERSONAL PAST HISTORY:** Have you ever had:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Abnormal Bleeding: | Y | N | Asthma: | Y | N | Hypertension: | Y | N |
| Abnormal Clotting: | Y | N | Diabetes: | Y | N | Sleep Apnea: | Y | N |
| Acid Regurgitation: | Y | N | Fainting Spell: | Y | N | Snoring: | Y | N |
| Anemia: | Y | N | Heart Attack: | Y | N | Thyroid Problems: | Y | N |
| Angina: | Y | N | Hepatitis: | Y | N | Weight Change past 12 M: | Y | N |
| Other Serious Illness: | Y | N | | | | | | |

Please describe questions with a "Yes" answer: ___________________________________
_____________________________________________________________________________

Have you ever received a transfusion? Y N If yes, what year? ______________________

Have you ever been tested for HIV? Y N If yes, what year? _____ Test results: o positive o negative

Do you wear: Contact Lenses: Y N Eye Glasses: Y N Hearing Aid: Y N Dentures: Y N

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): ______________________________

What is your height: ________________ What is your weight: ________________

**MEDICATIONS:** List dose or number of pills per day:

| Prescription Drugs | Non-Prescription (Vitamins; Herbs) |
|---|---|
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |

Regular Aspirin use : Y N Dosage & Frequency: ______________________

NSA (Advil, Motrin, Ibuprofen) : Y N Dosage & Frequency: ______________________

Cortisone Injections Past Year : Y N Dosage & Frequency: ______________________

Drug Allergy: Y N List drug(s) and type of reaction: ______________________________
_____________________________________________________________________________

Latex Allergy: Y N Tape Allergy: Y N

**SOCIAL:**

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:** List any medical problems that run in the family:
_____________________________________________________________________________

Date last seen by Primary Care Physician: ___________________________________

Primary Care Physician (Name) ______________________ (Telephone) ____________

(Address) ___________________________________________________________

**WOMEN PATIENTS ONLY:**

Number of pregnancies___Number of children___Last menstrual period_______ Did you breast feed Y N

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