Personal & Family History (Answer yes, no, amount or type to all questions below)	
Any personal or family history of trouble with anesthesia?	
Any personal or family history of easy bleeding?	
Please list any other significant family history below: **(High blood pressure, heart disease, diabetes, cancer etc.)**	

Do you smoke?		How much per day?		Cigars or Pipes?	
How many years?		Have you ever smoked?		When did you quit?	
CHILDREN: IS YOUR CHILD EXPOSED TO SMOKE?					
Any alcohol use?		Rare/daily/weekly/monthly/occasional?			
How many drinks monthly?		Any recreational drug use? (list drug)			

Review of Systems **Do you currently have, or have you had, problems with:**

Constitutional	**YES**	**NO**
Weight loss		
Night sweats		
Eyes		
Double vision		

Ear, Nose, Throat	**YES**	**NO**
Hearing loss		
Ear pain		
Noise /ringing in ears		
Dizziness		
Nasal		
Sore throat		
Trouble swallowing		
Hoarseness		

Cardiovascular	**YES**	**NO**
Chest pain/angina		
Heart trouble		
High blood pressure		

Neurological	**YES**	**NO**
Stroke		
Headache		

Allergic/Immunologic	**YES**	**NO**
Sneezing		
Itchy eyes/nose/throat		
Skin rash		
HIV		

Respiratory	**YES**	**NO**
Asthma		
Cough up blood		
TB		
Pneumonia		
Snoring		

Gastrointestinal	**YES**	**NO**
Indigestion/heartburn		
Ulcer		
Hepatitis		

Genitourinary	**YES**	**NO**
Prostate disease		
Kidney disease		

Musculoskeletal	**YES**	**NO**
Arthritis		

Endocrine	**YES**	**NO**
Diabetes		
Thyroid disease		

Hematologic	**YES**	**NO**
Bleeding disorder		

The above information is accurate to the best of my knowledge. Please sign below.

Patient Signature **Date**

(FOR OFFICE USE ONLY) **I have reviewed the above information with the patient.**

Have you traveled abroad within the past 3 months?

Physician Signature **Date** **Physician Signature** **Date**

PATIENT HEALTH HISTORY

Patient Name (Last, First)			
Date of Birth		Age	Sex
Address/City/ST/Zip			
Phone (Home)		Phone (Cell)	
Emergency Contact		Emergency Number	
Email		Occupation	
Referring Physician		Primary Care Physician	
Parent/Guardian Name		DOB	
Insurance Company		Insurance ID No.	
Insurance Subscriber		Subscriber DOB	
Pharmacy/Tel			

Chief Complaint (reason for today's visit including symptoms: pain, drainage etc. and timeframe of illness)

Past History

List any prior major injuries or illnesses (Explain in detail if prior injury pertains to today's visit)

Surgeries & Hospitalizations

(List Complications & Year)

Medications Including Aspirin & Vitamins

(List dosage & reason for taking)

Medication & Dosage	Reason	Medication & Dosage	Reason

Allergies to Medications, Anesthetics, Materials & Food

(Please list type of reaction: rash, hives, sneezing etc.)

Allergy	Reaction(s)	Allergy	Reaction(s)