Health History Form

Name: ____ Height____________ Weight ______________

Reason for Visit ____ Date of Injury _________________________

Primary Care Doctor ________________________________ Cardiologist ___________________________________

Current Medications
____
____
____
____
____
____
____

Surgical History
____
____
____
____
____
____
____

List Medication or Latex Allergies
____
____

Describe Any Difficulties with Anesthesia
____
____
____

Medical History

High Blood Pressure ___ Y ___ N
Heart Disease ___ Y ___ N
Cardiac Stents ___ Y ___ N
CHF ___ Y ___ N
Heart Murmur ___ Y ___ N
Heart Arrhythmia ___ Y ___ N
Chest Pain ___ Y ___ N
Pacemaker ___ Y ___ N
MVP ___ Y ___ N
A-Fib ___ Y ___ N
Asthma ___ Y ___ N
Bronchitis ___ Y ___ N
Pneumonia ___ Y ___ N
Tuberculosis ___ Y ___ N
Short of Breath ___ Y ___ N
Sleep Apnea ___ Y ___ N
CPAP Setting __________
Anemia ___ Y ___ N
Thyroid Disease ___ Y ___ N
Diabetes ___ Y ___ N
Dialysis ___ Y ___ N
HIV ___ Y ___ N
Hepatitis ___ Y ___ N

Liver Disease ___ Y ___ N
Blood Thinners ___ Y ___ N
Bleeding ___ Y ___ N
Factor V Leiden ___ Y ___ N
Blood Clots ___ Y ___ N
High Cholesterol ___ Y ___ N
GERD (Reflux) ___ Y ___ N
COPD ___ Y ___ N
Oxygen ___ Y ___ N
Arthritis ___ Y ___ N
Back Pain ___ Y ___ N
Joint Pain ___ Y ___ N
Weakness ___ Y ___ N
Rheumatoid Arth___ Y ___ N
Stroke ___ Y ___ N
Seizures ___ Y ___ N
Fainting Spells ___ Y ___ N
Kidney Problems___ Y ___ N
Dentures ___ Y ___ N
Infectious Dis. MRSA, C Diff
Staph or Other ___ Y ___ N
Hearing Loss ___ Y ___ N
Glasses ___ Y ___ N

Family History
Anemia ___ Y ___ N
Asthma ___ Y ___ N
Diabetes ___ Y ___ N
Heart Disease ___ Y ___ N
High Blood Press ___ Y ___ N
Malig Hyperthermia ___ Y ___ N
Cancer ___ Y ___ N
Type ____________________________
____

Social History
Marital Status S M D W
Tobacco Use:
Current ___ Y ___ N
How Much _______________________
Former ___ Y ___ N
Never ___ Y ___ N
Illicit Drug Use – Please List
____
____
Is Injury Work Related ___ Y ___ N
Occupation:
____