Health History

Patient Name: _____ Date: _____

Age: _____ Birthdate: _____/_____/_____ Height_____ Weight _____

What is the reason for your visit today?_____

Allergies: Are you allergic to any medications? _____Yes _____No
If yes, please list medication(s) and type of reaction(s): _____

_____

Latex allergy: _____Yes _____No **Sensitivity to adhesive tape:** _____Yes _____No

Medications: _____ Yes _____ No If yes, please list all medications you are currently taking including herbal medicines, diet pills, vitamins, supplements and over-the-counter medications:_____

_____

_____

_____

Do you take any illegal medications such as cocaine, methamphetamines or fentanyl? _____Yes ____No

Hospitalizations and/or previous surgeries: _____Yes _____No If yes, please list with dates and hospital where surgery was performed:

_____

_____

_____

Do you use tobacco, nicotine or marijuana products: _____Yes _____No If yes, which product, how frequent and for how long have you used this product?

_____

Have you or an immediate family member ever been diagnosed with a STAPH (MRSA) infection?

_____Yes _____No If yes, who/when:_____

Are you currently under the care of a physician(s): _____Yes _____No If yes, please list name of physician(s), phone number(s) and what you are being treated for:_____

_____

Who is your primary care physician/phone number? _____

Are you now or have you been under the care of a psychiatrist/therapist within the past 2 years:

_____Yes _____No If yes, for what:_____

Cardiovascular: (any personal history of the following)

High Blood Pressure	_____Yes	_____No
Coronary Artery disease	_____Yes	_____No
Angina/chest pain	_____Yes	_____No
Prior heart attack	_____Yes	_____No
Heart valve disease	_____Yes	_____No
Heart rhythm problems and/or pacemaker	_____Yes	_____No
Elevated cholesterol	_____Yes	_____No
DVT (Deep vein thrombosis)	_____Yes	_____No
Pulmonary Embolism	_____Yes	_____No
Mitral valve prolapse	_____Yes	_____No
Heart Murmur	_____Yes	_____No
Do you have a cardiologist?	_____Yes	_____No

If yes,who?/where?_____

Previous cardiac tests? (EKG, ECHO, stress test, etc.) ____Yes ____No
If yes, what/when? _____
_____
Sickle Cell disease or trait? _____Yes _____No
Other heart disease: _____

Endocrine:
Diabetes _____Yes _____No
If yes, on insulin _____Yes _____No
Thyroid disease _____Yes _____No

Renal:
Kidney problems _____Yes _____No
Kidney stones _____Yes _____No
Dark or chocolate colored urine _____Yes _____No

Gastrointestinal:
Do you drink alcohol? _____Yes _____No
If yes, how much/how often: _____
History of Hepatitis/liver problems _____Yes _____No
History of Ulcers _____Yes _____No
History of Acid Reflux _____Yes _____No
History of Blood Transfusions _____Yes _____No
Hiatal Hernia _____Yes _____No
Mononucleosis in the past 6 months _____Yes _____No

Pulmonary:
Asthma _____Yes _____No
If yes, ever required any steroids? _____Yes _____No
COPD/ Bronchitis/ Emphysema _____Yes _____No
Sleep Apnea _____Yes _____No
Sleep Study performed _____Yes _____No When and where:_____
Do you use a CPAP device/mask? _____Yes _____No
Name/number of treating doctor:_____
Recent respiratory illnesses _____Yes _____No
Difficulty climbing two flights of stairs _____Yes _____No

Neuro:
History of Loss of Consciousness _____Yes _____No
Stroke _____Yes _____No
Seizures _____Yes _____No
Peripheral Neuropathy _____Yes _____No
(numbness/weakness/shooting pains in limbs)
Back or neck trouble _____Yes _____No

Airway:
Caps/Crowns _____Yes _____No
Dentures or bridges _____Yes _____No
Loose or chipped teeth _____Yes _____No
TMJ syndrome _____Yes _____No
Neck/Cervical spine problems _____Yes _____No
History of previous difficult intubation _____Yes _____No

General:

Do you have any blood disorders _____Yes _____No
History of prolonged bleeding _____Yes _____No
Large scars or keloids _____Yes _____No
Skin Diseases _____Yes _____No
Cancer _____Yes _____No If yes, what type:_____

_____

Any other illness not listed above?:_____

_____

Anesthesia:

Any previous general anesthetic complications? _____Yes _____No
If yes, what was your reaction?

_____

_____

History of motion sickness? _____Yes _____No
Family members with anesthetic complications? _____Yes _____No
If yes, what was the reaction: _____

_____

Family history of malignant hyperthermia _____Yes _____No
High fever following strenuous exercise _____Yes _____No

Family History: check (X) if blood relatives have had any of the following.:

	Relationship to you		
• Breast cancer	_____		
• Keloid scars	_____	• Diabetes	_____
• Bleeding disorders	_____	• Heart disease/stroke	_____
• Prolonged Bleeding	_____	□ PE (Pulmonary Embolism)	_____

□ DVT (Deep vein thrombosis) _____

□Other:_____

Please explain any yes answers here, if not already explained above:

_____
_____
_____
_____
_____

_____ Date: _____
Patient Signature

_____ Date: _____
Philip J. Straka, M.D.