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HEALTH HISTORY SURVEY

Name: ______________________ Date: ______________

List allergies: ________________________________

List previous surgery and approximate dates: __________
____
____

List current medications: ________________________
____

Have you ever had general or twilight anesthesia?	No ( ) Yes ( )
Do you smoke? How many packs per day? ________	No ( ) Yes ( )
Do you have a chronic cough?	No ( ) Yes ( )
Do you have any breathing problems?	No ( ) Yes ( )
Have you had bronchitis, pleurisy, or pneumonia?	No ( ) Yes ( )
Have you had asthma?	No ( ) Yes ( )
Have you had a recent cold?	No ( ) Yes ( )
Have you ever had an abnormal chest x-ray?	No ( ) Yes ( )
Do you have problems with motion sickness?	No ( ) Yes ( )
Do you have any bleeding tendencies?	No ( ) Yes ( )
Have you ever been anemic?	No ( ) Yes ( )
Have you ever had a heart attack?	No ( ) Yes ( )
Have you ever had chest pain related to your heart?	No ( ) Yes ( )
Do you have a heart murmur or irregular beat?	No ( ) Yes ( )
Have you ever had high blood pressure?	No ( ) Yes ( )
Do you ever wake up at night short of breath?	No ( ) Yes ( )
Do you have diabetes?	No ( ) Yes ( )
Have you ever had thyroid problems?	No ( ) Yes ( )
Have you ever had a stroke?	No ( ) Yes ( )
Have you ever had epilepsy, seizures, or fainting spells?	No ( ) Yes ( )
Do you have frequent headaches or migraine?	No ( ) Yes ( )
Have you ever had eye problems or dry eye syndrome?	No ( ) Yes ( )

continue on other side

Is there a family history of glaucoma? No ( ) Yes ( )
Do you wear contact lenses? No ( ) Yes ( )
Do you have chronic bladder problems or kidney disease? No ( ) Yes ( )
Have you passed bloody urine? No ( ) Yes ( )
Have you ever been jaundiced? No ( ) Yes ( )
Have you ever had hepatitis? No ( ) Yes ( )
Do you have any history of hearing loss? No ( ) Yes ( )
Have you ever had a broken nose? No ( ) Yes ( )
Do you have chipped, loose, or capped teeth, dentures or braces? No ( ) Yes ( )
Do you have any sores in you mouth that do not heal? No ( ) Yes ( )
Are you prone to fever blisters? No ( ) Yes ( )
Do you have any hoarseness or trouble swallowing? No ( ) Yes ( )
Do you have any lumps in your neck? No ( ) Yes ( )
Do you have stomach, bowel, or gallbladder problems? No ( ) Yes ( )
Have you ever had bloody bowel movements? No ( ) Yes ( )
Do you use alcohol? No ( ) Yes ( )
If "Yes", how much? ______________________________
Do you use aspirin or other over-the-counter drugs? No ( ) Yes ( )
Have you ever had thrombophlebitis or do your ankles swell? No ( ) Yes ( )
Do you have any arm or leg numbness or weakness? No ( ) Yes ( )
Do you have any physical disabilities or orthopedic problems? No ( ) Yes ( )
Have you ever received radiation therapy? No ( ) Yes ( )
Have you ever had psychiatric care or counseling? No ( ) Yes ( )
Have you ever used "street" drugs? No ( ) Yes ( )
Do you have any reason to believe that you have been exposed to the AIDS virus? No ( ) Yes ( )
Is there any reason to believe that you are pregnant? No ( ) Yes ( )

Height __________ Weight __________

Comments: ____
____

Patient's signature: ______________________________________

Reviewed by (surgeon): ____________________ Date __________

Reviewed by (anesthesia): ____________________ Date __________