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| --- | --- | --- | --- |
| **Heart Conditions** | **Gastrointestinal Conditions** | **Lung Conditions** | **Muscle/ Skeletal Conditions** |
| \_\_NONE | \_\_NONE | \_\_NONE | \_\_NONE |
| \_\_Heart Attack | \_\_Hiatal Hernia | \_\_Asthma | \_\_Arthritis |
| \_\_Heart Condition | \_\_Ulcers | \_\_Emphysema | \_\_Rheumatoid |
| \_\_Chest Pain | \_\_Gallbladder Problems | \_\_Bronchitis | \_\_Back or Neck Pain |
| \_\_Heart Failure | \_\_Juandice | \_\_Chronic Cough | \_\_Stiff Jaw |
| \_\_Heart Disease | \_\_Hepatitis | \_\_Shortness of Breath | \_\_Numb Arms or Legs |
| \_\_Heart Murmur | \_\_Liver Disease | \_\_Difficult PM Breathing | \_\_Tingling Arms or Legs |
| \_\_Shortness of Breath | \_\_Colostomy | \_\_Recent Cold | \_\_Ulcers on Legs |
| \_\_Swelling of Ankles | \_\_Stomach Problems | \_\_Sinus Infection |  |
| \_\_Irregular Heart Beat | \_\_Intestinal Problems | \_\_Respiratory Infection |  |
| \_\_Mitral Valve Prolapse | \_\_Diverticulitis | \_\_Tuberculosis |  |
| \_\_Rheumatic Fever | \_\_Pancreatitis |  |  |
| \_\_High Blood Pressure |  |  |  |
| \_\_Pacemaker |  |  |  |
| \_\_ICO (implantable) |  |  |  |
| \_\_Cardioverter Defibril. |  |  |  |
| Other/ Notes | Other/ Notes | Other/ Notes | Other/ Notes |
| **Neurological Conditions** | **Infectious Diseases** | **Urinary Conditions** | **Blood Conditions** |
| \_\_NONE | \_\_NONE | \_\_NONE | \_\_NONE |
| \_\_Epilepsy | \_\_Flu | \_\_Kidney Stones | \_\_Anemia |
| \_\_Fainting Spells | \_\_Measles | \_\_Chronic Infection | \_\_Bruise Easily |
| \_\_Dizzy Spells | \_\_Mumps | \_\_Kidney Failure | \_\_Bleeding Problems |
| \_\_Stroke | \_\_Small Pox | \_\_Bladder Infection | \_\_Leukemia |
| \_\_Seizures | \_\_Tetanus | \_\_Bladder Problems | \_\_Sickle Cell Disease |
| \_\_Parkinson’s Disease | \_\_Typhoid | \_\_Hemodialysis |  |
| \_\_Chronic Headaches | \_\_Chicken Pox | \_\_Peritoneal Dialysis |  |
| \_\_Multiple Sclerosis | \_\_MRSA | \_\_Urine/ Kidney Problem |  |
| \_\_Cerebral Palsy | \_\_Any skin infection please specify  |  |  |
| \_\_Paralysis |  |  |  |
| \_\_Muscle Weakness |  |  |  |
| \_\_Neuritis |  |  |  |
| Other/ Notes | Other/ Notes | Other/ Notes | Other/ Notes |

|  |  |
| --- | --- |
| **Miscellaneous Conditions** | **Mouth and Teeth Conditions** |
| \_\_ NONE | \_\_NONE |
| \_\_Diabetes | \_\_Mouth Sores |
| \_\_Thyroid Problems | \_\_Tooth Decay |
| \_\_Cancer (What Type of Cancer)\_\_\_\_\_\_\_\_\_\_ | \_\_Chipped Teeth |
| \_\_Mental Illness | \_\_Loose Teeth |
| \_\_Emotional Problems | \_\_Damaged |
| \_\_Body Dysmorphic Disorder | \_\_Full Dentures |
| \_\_Glaucoma | \_\_Partial Dentures |
| \_\_Hearing Loss |  |
| \_\_Congenital Conditions |  |
| \_\_Attention Deficit |  |
|  \_\_Learning Disorders |  |
| \_\_Eye Problems |  |
| \_\_Skin Problems |  |
| \_\_Mononucleosis |  |
| \_\_Eczema |  |
| \_\_Gonorrhea |  |
| \_\_Syphilis |  |
| \_\_Venereal Disease |  |
| \_\_Weight Loss |  |
| \_\_HIV |  |
| \_\_Polio |  |
| \_\_Fever |  |
| \_\_Artificial Joints |  |
| \_\_Herpes Simplex I |  |
| \_\_Herpes Simplex II |  |
| \_\_Lupus |  |
| \_\_Other autoimmune disease \_\_\_\_\_\_\_\_\_\_\_ |  |
| Other/ Notes | Other/ Notes |

**Patient Past Surgeries/ Hospitalizations (If none, please check none)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surgery/ Hospitalization** | **Date** | **Anesthesia Complications** | **Doctor/ Notes** |
| \_\_NONE |  |  |  |
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Have you previously had anesthesia? \_\_\_\_yes \_\_\_\_no

Previous Anesthetics \_\_\_\_Local \_\_\_\_IV Sedation \_\_\_\_General \_\_\_\_Spinal/Epidural \_\_\_\_NONE

Have you ever had any problems with anesthesia? \_\_\_\_no \_\_\_\_yes (please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you or a blood relative ever had an allergic reaction or history of complications while under the influence of anesthesia? \_\_\_\_no \_\_\_\_yes (please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies (If none, please check none)**

|  |  |  |
| --- | --- | --- |
| **Allergy** | **Reaction** | **Notes** |
| \_\_NONE |  |  |
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**Current medications, please include ANY type of birth control (name of birth control is needed) and nonprescription drugs (if none, please check none). If taking any medications we require the dosage.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drug** | **Dosage** | **How often** | **Prescribed by** | **Reason** |
| **\_\_NONE** |  |  |  |  |
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**Social History**

Do you use tobacco or smoke? \_\_\_\_yes \_\_\_\_no

 If yes, what type? \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever previously used tobacco or smoked? \_\_\_\_yes \_\_\_\_no

 If yes, how many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many packs per day of cigarettes did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_yes \_\_\_\_no

 If yes, what type and how many drinks per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you ever been in treatment? \_\_\_\_yes \_\_\_\_no

Do you use or have you ever used IV or “street” drugs? \_\_\_\_yes \_\_\_\_no

 If yes, what type and amount? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height in inches only \_\_\_\_\_\_\_\_\_\_\_\_

Weight in pounds only\_\_\_\_\_\_\_\_\_\_\_

Will you accept a blood transfusion if needed? \_\_\_\_yes \_\_\_\_no

Have you had previous blood transfusions? \_\_\_\_yes \_\_\_\_no

Have you taken any steroid, cortisone or prednisone therapy in the 12 months? \_\_\_\_yes \_\_\_\_no

Have you had radiation therapy? \_\_\_\_yes \_\_\_\_no

Have you ever or do you currently use a bisphosphonate drug? This type of drug is used to treat osteoporosis or in conjunction with chemotherapy. A few examples are Fosamax, Boniva, Alendronic Acid, Prolia, Reclast, Zometa, and more. \_\_\_\_yes \_\_\_\_no

Have you ever or do you currently take Phenteramine or Redux? \_\_\_\_yes \_\_\_\_no

Please list preferred pharmacy (list only one hometown pharmacy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female Questions**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **N/A** | **NO** | **YES** | **NOTES** |
| **Do you have regular periods** |  |  |  |  |
| **Last Menstrual Period**  |  |  |  |  |
| **Are you going through menopause** |  |  |  |  |
| **Are you currently pregnant or nursing** |  |  |  |  |

Primary care doctor name and phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist name and phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Orthodontist name and phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes or anything you want Dr. Henry to know \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_