

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 _____
- Bleeding disorders _____
- Prolonged Bleeding _____
- DVT (Deep vein thrombosis) _____
- Other: _____
- Diabetes _____
- Heart disease/stroke _____
- PE (Pulmonary Embolism) _____

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

Patient Signature

Date: _____

Philip J. Straka, M.D.

Date: _____