History & Physical

Revised 5/2006

Name_____________________________________ Age_________ Date _________________

Referred By: ____

Date of Injury: ____

Reason for Consult and Onset of Condition ______________________________________

____

Medical History:

1) Previous or Current Medical Problems: ______________________________________

____

2) Do you have or have you ever had any form of hepatitis or HIV? ____________________

3) ALLERGIES TO MEDICATIONS: ____

ALLERGIES TO FOODS: ____

Are you allergic to iodine (shellfish, IVP dye for kidney x-rays or dye for arteriogram)? Yes No

Are you allergic to latex (natural rubber, bananas or kiwi)? Yes No

4) Medication you take regularly or occasionally ____________ ____________ ____________

____________ ____________ ____________

Do you ever take diuretics (water pills)? Yes No

5) Do you bruise easily? Yes No
Have you ever had problems with bleeding during surgery? Yes No

Do you ever take aspirin or aspirin products? Yes No Circle all that apply: Goody or BC Powder

Motrin Advil Nuprin Ibuprofen Naprosyn Anaprox Other: __________________

Do you take vitamins and/or herbs (Fever Few, Green Tea, Ginko Biloba, Willow Bark, Vitamin A, Vitamin E, etc.)? Yes No
If yes, please list: ____

6) Past Surgical Procedures (include dates): ____________________________________

Have you had any anesthesia-related problems during or after surgery? Yes No

If yes, please explain: ____

7) Hospitalization (including serious injuries {dates}) ____________________________

____

Family History:
Has anyone in your family had any of the following:

Heart Disease?	No	Yes	Who? ____________________
High Blood Pressure?	No	Yes	Who? ____________________
Cancer?	No	Yes	Who? ____________________
Diabetes?	No	Yes	Who? ____________________

EENT: Do you ever have problems with your eyes, ears, nose, or throat? Yes No

If yes, explain: ____

Do you smoke? (If yes, how many packs per day and for how long? ____________) Yes No
Does your spouse or anyone in your household smoke? Yes No
Cardiovascular: Do you have any problems with your heart (chest pain, heart attack, high blood pressure, heart murmur)? Yes No
If yes, explain: ______________________________
Do you ever get short of breath? Yes No
Do your ankles ever swell? Yes No

GI:
Do you have problems with ulcers? Yes No
Have you ever vomited blood? Yes No
Have you ever passed blood in your stools? Yes No
Do you have diabetes? Yes No
Have you had gallbladder trouble? Yes No
Have you ever had yellow jaundice? Yes No

GU:
Have you ever had any trouble with kidney stones? Yes No
Have you ever had any trouble with kidney infections? Yes No
Do you have trouble with bladder infections? Yes No
Men: Do you have prostate trouble? Yes No
Women: Are your periods regular? Yes No
Any excessive bleeding? Yes No
Is there any chance you could be pregnant? Yes No

Neuromuscular: Do you have seizures? Yes No
Have you ever had a stroke? Yes No

Miscellaneous: Have you ever had blood clots in your legs (phlebitis)? Yes No
Have you ever had blood clots in your lungs (pulmonary embolus)? Yes No
Do you have any history or have you ever been told that you have any anxiety disorders? (i.e., panic/anxiety attacks, obsessive compulsive disorder, body dysmorphic disorder)? Yes No
Do you have sickle cell anemia? Yes No

Do you currently have any dental problem? (i.e., loose teeth, periodontal disease, other) Please List: ______________________________ Yes No

Have you recently had a dental procedure? If so, what procedure? Yes No
____

DO YOU HAVE OR HAVE YOU HAD ANY MEDICAL PROBLEMS THAT I HAVE NOT ASKED YOU ABOUT? Yes No
If yes, please explain: ______________________________

HONEST ANSWERS TO THE FOLLOWING QUESTIONS ARE ABSOLUTELY CRUCIAL FOR YOUR SAFETY DURING ANESTHESIA:

Do you drink alcohol? Yes No
If yes: How much? ____________ How often? ____________

Do you now or have you ever used illegal street, or recreational drugs? Yes No
If yes, please explain: ______________________________

"The above information is correct and complete to the best of my knowledge"

BP: ____________

____
(Signature)

Pulse: ____________

Height: ____________

Weight: ____________

____
(Physician's Signature)

Checked By: ____________