

**HEALTH HISTORY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BMI (body mass index, if known)\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been vaccinated for COVID-19? \_\_\_ Yes \_\_\_ No Booster? \_\_\_ Yes \_\_\_ No

**SOCIAL HISTORY:**

Are you currently using tobacco? \_\_\_Yes \_\_\_No If yes, what year did you start? \_\_\_\_\_\_\_\_\_\_\_

Packs per day \_\_\_\_\_\_\_\_\_\_\_\_ Smokeless tobacco? \_\_\_\_Yes \_\_\_\_No

Have you used tobacco in the past? \_\_\_Yes \_\_\_\_No **If yes,** what **year** did you start and what **year** did you quit?

Year started \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year quit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you vape? \_\_\_Yes \_\_\_No **If yes,** is there nicotine in the vape? \_\_\_ Yes \_\_\_ No

Are you currently using nicotine from any other source? \_\_\_ Yes \_\_\_\_ No

Alcohol use: \_\_\_Never \_\_\_\_Rare \_\_\_\_Moderate \_\_\_\_ Daily

Recreational drug use: \_\_\_Yes \_\_\_\_No If yes, what drug(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you approved for Medical Marijuana use? \_\_\_\_Yes \_\_\_No

Chronic opioid user? \_\_\_Yes \_\_\_No If yes, do you have a pain contract? \_\_\_Yes \_\_\_No

Do you exercise routinely? \_\_\_Yes \_\_\_No

Can you climb a flight of stairs without getting short of breath? \_\_\_Yes \_\_\_No

**MEDICATIONS/ALLERGIES:**

Have you ever had an allergic reaction to any medications? \_\_\_Yes \_\_\_No If yes, what medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and what reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an allergic reaction to X-ray or Contrast Dye? \_\_\_\_Yes \_\_\_No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a latex allergy? \_\_\_Yes \_\_\_No Have you ever had a tape/adhesive allergy? \_\_\_Yes \_\_\_No

Prescription Medications Dosage (mg) Frequency (once, twice per day, etc. )

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

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Non-Prescription Medications (including over-the-counter drugs, supplements, herbs, vitamins, aspirin, etc)

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

Preferred Pharmacy you use:

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

Have you taken cortisone/steroid drugs? \_\_\_Yes \_\_\_No

Have you ever had blood products transfused? \_\_\_Yes \_\_\_No If yes, when? \_\_\_\_\_\_\_\_\_ where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE COMPLETE PAGE 2 OF HISTORY**

**Page 2**

**PAST MEDICAL HISTORY:** Please check illnesses / conditions that you have had or currently have:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Asthma | Bleeding tendencies | Blood clots | Bronchitis | Cancer (type) | Diabetes | Elevated cholesterol |
| Heart disease  | Hepatitis  | High blood pressure | HIV | Sleep apnea | Glaucoma | Kidney disorder/stones |
| Jaundice  | Obesity | Pneumonia | STD | Nervous disorder | Stroke/TIA | Tuberculosis |
| Reflux/PUD | Rheumatic fever | Cold sores/ fever blisters | Hives/rash | Eczema | Frequent urination | Burning/painful urination |
| Blood in urine | Skin diseases | Thyroid disorder | Dizziness/loss of consciousness | Easy bruising | Heavy bleeding after surgery | Slow to heal after cuts |
| Multiple sclerosis | Fragile skin / burn easily | Other |  |  |  |  |

Are you currently experiencing any cold or flu-like symptoms? \_\_\_\_\_ yes \_\_\_\_ no

**SURGICAL HISTORY:** Previous operations or hospitalizations.

Please list procedure, year, and describe anesthesia complications (if any):

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

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Have you had any serious injuries, broken bones, etc? Yes\_\_\_ No\_\_\_ If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY:**

Please check illnesses that have occurred in any of your **BLOOD RELATIVES,** and list which relative(s):

(M = mother. F = father. B = brother. S = sister. PGM = paternal grandmother. MGM = maternal grandmother PGF = paternal grandfather. MGF = maternal grandfather. A = aunt. U = uncle. C = cousin. CH = child. GC = grandchild)

Bleeding tendencies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nervous disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer (type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Woman Only:**

Are you pregnant? \_\_\_Yes \_\_\_No

During pregnancy do you have hypopigmentation or masking? \_\_\_Yes \_\_\_No

Do you have regular periods? \_\_\_Yes \_\_\_No

Are you going through menopause? \_\_\_Yes \_\_\_No

Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or responsible party signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

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