Patient Name: _____ Date of Birth: _____

Past Medical History:

Do you or have you ever had any of the following medical conditions:

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune disorder
- ☐ Bleeding disorder
- ☐ Bone Disorder
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Chronic Pain
- ☐ COPD
- ☐ Diabetes
- ☐ Depression/Anxiety
- ☐ Emphysema
- ☐ Eye problems
- ☐ Hearing Aids
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Heart Attack
- ☐ HIV
- ☐ Innocent Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Kidney Disease
- ☐ Liver Disease, Hepatitis
- ☐ Lung Disease
- ☐ Migraines
- ☐ Muscle Disorder
- ☐ Neurological Problems
- ☐ Prostate Problems (male)
- ☐ Reproductive Problems
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Stent Placement
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Do you require antibiotics prior to dental or other procedures
- ☐ Other medical conditions that require medications:

_____

_____

In addition to the questions above, for Pediatric Patients:

- ☐ Premature Birth Delivery at _____ weeks
- ☐ Asthma, reactive airway disease, wheezing, or any use of nebulizer at home

Surgical History:

Have you ever had surgery or received anesthesia for any procedure? _____

If yes, please list the type of surgery/procedure and the year performed:

_____

Do you or any of your direct family members have a history of Malignant Hyperthermia or other adverse reaction to anesthesia?

- ☐ Yes
- ☐ No
- ☐ Unknown

Current Medication:

List all medications taken regularly with dosage instructions (include prescription AND over the counter medications, vitamins, supplements):

_____

_____

Allergies:

List any medication, food, Latex or environmental allergies along with their reaction:

_____

Family History:

Have any of your immediate family members had any of the following conditions:

	Relationship		Relationship
☐	Cancer	☐	Diabetes
☐	Hearing Loss	☐	Heart Disease
☐	Thyroid Disease	☐	Brain Tumor
☐	Bleeding Disorders	☐	Anesthesia Problems

Social History:

Do you smoke or have you ever? _____ If so, how much a day?_____ how much a week?_____

How old were you when you started smoking?_____How old were you when you quit smoking?_____

Do you drink alcohol? _____ If yes, how many drinks per day? _____ Per week? _____

Do you or have you ever had any dependency to drugs? _____ If so, to what drug(s)? _____

For Pediatric Patients:

Does anyone in the house smoke? _____ Does child attend daycare?_____

Vaccinations:

Have you had a Flu Vaccine? _____ Have you had a Pneumonia Vaccine?_____

Other:

Do you have a Healthcare Proxy or Advanced Directive? _____