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
- [ ] Do you require antibiotics prior to dental or other procedures
- [ ] Other medical conditions that require medications: ______________________________
- [ ] Prostate Problems (male)
- [ ] Reproductive Problems
- [ ] Seasonal Allergies
- [ ] Seizure Disorder
- [ ] Stent Placement
- [ ] Stroke
- [ ] Thyroid Disorder

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:

	Condition	Relationship		Condition	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? ____________