Health History Form:

Name of Patient:____

Date of Birth:__________/__________/____________

Height:_________________

Weight:________________

Are you currently under a physician's care? Yes_________ No___________

Date of Last Physician Visit:__________/___________/_____________

Name of Physician and type of specialist:

____

Phone of Physician/Specialist: ( ) _______________________________

Allergies:

Do you have any Allergies? Yes_____________ No_______________

If Yes, Please list your allergies and the allergic reaction:

Allergy____

Allergic Reaction:____

Do you have any allergies to Latex? Yes_______________ No____________

Medications: *(if you need more space please write on last page of forms)*

Please list any medications you take, including the dosage and what it is for?

Medication_____________________________ Dosage:_________________

Reason for taking____

Medication_____________________________ Dosage:_________________

Reason for taking____

Medication_____________________________ Dosage:_________________

Reason for taking____

Surgeries

Please list any previous surgeries, the date of the procedure, and location. *(if you need more space please write on last page of forms)*

Surgery:____

Date:_____/_____/______

Location of Surgical Center/Hospital:___________________________

Surgery:____

Date:_____/_____/______

Location of Surgical Center/Hospital:___________________________

Surgery:____

Date:_____/_____/______

Location of Surgical Center/Hospital:___________________________

Review of Systems: (circle any issues that pertain to you)

Cardiovascular

High or low blood pressure?

Do you take medication?

Any previous procedures?

Other:

Pulmonary

Asthma   COPD   Cough   Shortness of breathe   Wheezing

Other:

Have you had any problems with anesthesia?

Gastrointestinal

Abdominal pain   Abdominal bloating   Unexpected weight change?

Other:

Dematology (skin)

Do you have regular exams to check for skin cancer?

List any procedures___________________________________

Ear/ /Nose/Throat

Ear Conditions (including congenital)

Do you have any hearing loss, if yes, what type?

Do you wear a hearing aide?

Nasal Conditions

Do you have any trouble swallowing?

Do you wear dentures or have removable dental prostheses?

List any procedures specific to Ears/Nose and Throat

____

____

Eye Conditions

Visual Disturbances, If yes, do you wear glasses/contacts?

List any procedures specific to Eyes

____

Endocrine

Do you have Diabetes? Yes________ No_________

If yes, What Type and how is it controlled?___________________________

____

Other:

Neurological/Psychological

Anxiety Depression Migraines Trouble sleeping

Trouble concentrating Seizures

Other:

Musculoskeletal

Joint pain Arthritis Prosthetic limb Reduced manual dexterity

Gait problems Back Pain

Other:

Immunology/Infectious Disease

HIV Immunodeficiency

Other:

Hematologic

Bruises/Bleeds Easily Anemic

Other:

Oncology (Cancer)

Have you have had Cancer? Yes______ No_______

If yes, Please answer the following questions:

Type of cancer and location

____

Did you require surgery? Explain______________________________

Did you need to have Chemotherapy? Explain____________________

Did you need to have Radiation treatment? Explain________________

____

Do you have regular follow ups?______________________________

Date of Last CT scan_______________________________________

Location where you receive CT scans___________________________

Please list any other information you would like your Anaplastologist to know about your health history or current conditions.