
Health Information Form

Health Information Form: This form provides specific information about your health and also risk factors that will be addressed prior to surgery.

PATIENT INFORMATION

Patient Name:

Reason for visit:

Height: Feet Inches Weight: Lbs

Current Primary Care Doctor

List of all Surgeries

Check if no prior surgeries

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List of all Medications including non-prescriptions (Vitamins, Herb)
May provide a copy of medications list

Check if not taking any medications

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Regular aspirin use Yes No
NSAIDS (Advil, Motrin, Ibuprofen) Yes No

Do you have or have you had any of the following within the last 10 years:
(Circle for each, give date occurred if yes)

Abnormal Clotting	Yes	No	Hay fever	Yes	No
Aids/HIV	Yes	No	Headache	Yes	No
Arthritis	Yes	No	Heart trouble	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No
Bronchitis	Yes	No	High Blood pressure	Yes	No
Cancer	Yes	No	Kidney Problems	Yes	No
Depression	Yes	No	Pneumonia	Yes	No
Diabetes	Yes	No	Sinus problems	Yes	No
Dizziness	Yes	No	Sleep apnea	Yes	No
Ear infection	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Tonsilitis	Yes	No
Facial pain	Yes	No	Tuberculosis	Yes	No
Fever/Blisters	Yes	No	Ulcers	Yes	No
Thyroid	Yes	No	Others :	Yes	No

Do you smoke? Yes No If yes how much? Pack(s)/Day

How long? years

Do you drink alcohol Yes No If yes how much? Pack(s)/Day

How long? years

Are you pregnant or planing to become pregnant? Yes No

Do you have problems with scarring? Yes No

Any history of problems with anesthesia? Yes No

Any bleeding or bruising problems? Yes No

Allergies

Check if no allergies

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

Signature

Date