Patient Name: ___________________________________ **DOB:** _____________

Past Health History: **(Please circle any condition you have been previously diagnosed)**

Cancer: N Y If yes, what type? ____

Head and Face:
- cluster headache, facial paralysis, migraine headache, tension or stress headache, temporal arteritis.

Eyes:
- Amblyopia, cataracts, dacryocystitis, dry eyes, glaucoma

Ears:
- cerumen impaction, cholesteatoma, chronic or frequent ear infections, middle ear effusion, hearing loss, Meniere's disease, tympanic membrane perforation, hearing aids

Nose and Sinus:
- sinusitis, deviated nasal septum, epistaxis, nasal allergies, nasal polyps,

Mouth and Throat:
- tonsil/adenoid enlargement, chronic/recurrent tonsillitis, cold sores, peritonsillar abscess, salivary gland duct stone, sleep apnea, TMJ

Cardiovascular:
- atrial fibrillation, atrial flutter, blocked carotid artery, cardiomyopathy, CHF, coronary artery disease, DVT, elevated blood cholesterol, MI, heart valve defect, hypertension, mitral valve prolapse, peripheral vascular disease, Raynaud's disease, rheumatic fever

Respiratory:
- asthma, bronchiectasis, COPD, croup, cystic fibrosis, pneumonia, pneumothorax, pulmonary embolus, sarcoidosis, TB

Gastrointestinal:
- gastroesophageal reflux, hepatitis, laryngeal reflux/LPR

Kidneys and Urinary Tract:
- kidney disease, kidney stone, renal failure, renal insufficiency

Musculoskeletal:
- osteoarthritis, rheumatoid arthritis, chronic fatigue syndrome, disc disorder in back, disc disorder in neck, fibromyalgia, gout, myasthenia gravis, osteoporosis, spinal stenosis

Integumentary:
- acne rosacea, severe acne, actinic keratosis, eczema, keloid, lichen planus, Lyme disease, neurofibromatosis, psoriasis, scleroderma, shingles, Stevens-Johnson syndrome

Neurologic:
- Alzheimer's disease, aneurysm/AVM of blood vessel in the brain, dementia, epilepsy, meningitis, multiple sclerosis, neuralgia, Parkinson's disease, pituitary tumor, restless leg syndrome, sleep disorder, stroke (CVA), tic douloureux, transient ischemic attack (TIA), brain tumor.

Psychiatric:
- alcohol or drug treatment, alcoholism, chronic anxiety, ADHD, bi-polar disorder, depression, PTSD

Endocrine:
- diabetes, goiter, Graves' disease, hyperparathyroidism, hyperthyroidism, hypoparathyroidism, hypothyroidism, morbid obesity, obesity, thyroid nodule, thyroiditis.

Hematologic and Lymphatic:
- anemia, clotting disorder, hemophilia, sickle cell disease, sickle cell trait, Von Willebrand’s disease.

Immunologic:
- anaphylaxis, autoimmune disorder, HIV infection, systemic lupus, MRSA, angioedema, Sjogren's Syndrome, urticarial.

Other Previously Diagnosed Problems: ____

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? _____Yes_____No
If yes, please list type of problems ____
____
____

List ALL surgeries you have had during your lifetime:
____
____

Have you ever been hospitalized for more than 24 hours for non-surgical reasons? _____Yes_____No
If yes, list the reasons for hospitalizations____
____

Family History *("Family member" means mother, father, siblings ONLY)*

Cancer-List type____

Head and Face-Facial paralysis, migraines ____

Cardiovascular-Hypertension, Heart Disease, CHF ____

Ears (Meniere's disease, chronic ear infections, hearing loss)____

Nose and Sinuses (chronic sinus disease, nasal allergies)____

Respiratory-Asthma, COPD____

Neurologic-Stroke, Dementia____

Endocrine (thyroid disease, diabetes)____

Hematologic/Lymphatic____

Allergic/Immunologic____

Have *ANY* family members had any problems w/Anesthesia/bleeding/clotting? Y N Whom?
____

Social History

Current tobacco usage: Y N Type:_____________ Amount per day:_________________
Past (discontinued) use of tobacco products: Y N Date/Year Stopped___________________
Type:______________ Amount per day :________________ Duration of use (in years):____________

Second-hand smoke exposure: Y N

Current use of alcoholic beverages: Quantity ____________________ Frequency ______________
Caffeine use: Quantity ____________________ Frequency ______________