HISTORY & PHYSICAL

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Patient Name:____Age:__________Height_____'______" Weight______

1.Disease History: Please mark appropriate box:

Lung	Past	Present	No	Lung	Past	Present	No	Lung	Past	Present	No
Bronchitis	____	____	____	Pneumonia	____	____	____	Sinusitis	____	____	____
Emphysema	____	____	____	Pleurisy	____	____	____	Respiratory Infections	____	____	____
Asthma	____	____	____	T.B.	____	____	____	Shortness of Breath	____	____	____

Vascular	Past	Present	No	Vascular	Past	Present	No	Vascular	Past	Present	No
High Blood Pressure	____	____	____	Circulation Problems	____	____	____	Sickle Cell Anemia	____	____	____
Heart Attack	____	____	____	Rheumatic Fever	____	____	____	Bleeding/Bruising	____	____	____
Chest Pains	____	____	____	Anemia	____	____	____	Heart Murmur	____	____	____
Stroke	____	____	____	Heart Disease	____	____	____	Phlebitis	____	____	____

Systematic	Past	Present	No	Systematic	Past	Present	No	Systematic	Past	Present	No
Diabetes	____	____	____	Convulsions	____	____	____	Jaundice	____	____	____
Glandular/Thyroid	____	____	____	Glaucoma	____	____	____	Numbness	____	____	____
Kidney/Bladder	____	____	____	Arthritis	____	____	____	Muscle Weakness	____	____	____
Fainting	____	____	____	Stomach/Bowel	____	____	____	Comm. Disease	____	____	____
Headache/Migraines	____	____	____	Hepatitis	____	____	____	Cancer	____	____	____

If you marked any of the past/present boxes above, please explain each one:

2. Drug History: In the past six months, have you taken any of the following drugs:

	Past	Present	No		Past	Present	No		Past	Present	No
Steroids	____	____	____	Insulin (Diabetes)	____	____	____	Heart Medication	____	____	____
Birth Control Pills	____	____	____	Narcotics	____	____	____	Water Pills	____	____	____
Antibiotics	____	____	____	Blood Thinners	____	____	____	Tranquilizers	____	____	____
Thyroid Medication	____	____	____	Aspirin	____	____	____	Other ____________	____	____	____
Blood Pressure	____	____	____	Arthritis/Joint Meds	____	____	____				

If you marked any of the past/present boxes above, please explain each one:

List all of the medications or substances that you are currently taking:

3. **Allergies and Reactions: If none, Please state "None"**_______________

Narcotic: Drug____ Reaction:____
LocalAnesthetic:Drug____________________________________ Reaction:____
Antibiotic:Drug____ Reaction:____
Environmental:List______________________________________ Reaction:____
Topical:List____ Reaction:____
Other: List____ Reaction:____

4. **Please list all hospitalizations and operations that you have had and give approximate dates:**

5. **Have you or your family members had problems with anesthesia? If yes, please explain:**

6. Do You Smoke?______________________________ If yes, how much? __________________________________
7. Do you drink alcohol?__________________________ If yes, how much?__________________________________
8. Date of last menstrual period? ______________________ Are you menopausal?______________________________
9. Could you be pregnant?___________________________
10. Do you have any physical limitations?____
11. Are the any health problems not mentioned above that we should know about?__________________________________

The answers that I have given represent a true and complete history to the best of my knowledge.

Signature____ Date:__________________________________