



SAN ANTONIO SURGICAL ARTS

HEALTH HISTORY

Date: _____ Name: _____ Male Female

Height: _____ Weight: _____ DOB: ____/____/____ Age: _____

Tell us why you came to the doctor today. _____

ALLERGIES TO:

- Latex YES NO
- Penicillin YES NO
- Local Anesthesia YES NO
- Aspirin YES NO
- Other Allergies _____

LIST ALL MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING

Continued on next pg.

HAVE YOU HAD:

- Operations YES NO Describe: _____
- Hospitalizations YES NO Describe: _____
- Cosmetic Surgery YES NO Describe: _____
- Implanted Devices /Plates or Screws? YES NO Describe: _____
- Artificial Joints YES NO Describe: _____

ILLNESSES:

- | | | | | | |
|------------------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| 1. Eye Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 22. Cough | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Glaucoma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 23. Ulcers | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Ear Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 24. Liver Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Sinus Trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 25. Hepatitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Nasal Obstruction | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 26. Cirrhosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Dental Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 27. Jaundice | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Heart Trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 28. Seizures/convulsions | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Heart Attack | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 29. Stroke | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Angina (Chest Pain) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 30. Prolonged Bleeding | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Rheumatic Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 31. Frequent Bruising | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Heart Murmur | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 32. Blood Thinners | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. Congenital Heart Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 33. Frequent Nosebleeds | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 13. Heart Surgery | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 34. Anemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 14. Pacemaker | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 35. Kidney Failure | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 15. Abnormal Heart Beat | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 36. Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 16. High Blood Pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 37. Thyroid Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 17. Low Blood Pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 38. Arthritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 18. Shortness of Breath | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 39. Osteoporosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 19. Lung Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 40. Cancer or Tumor | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 20. Emphysema | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 41. X-ray Treatment | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 21. Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | 42. Chemotherapy | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

ADDITIONAL QUESTIONS

- 43. Do you have clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? YES NO
- 44. Do you smoke or use smokeless tobacco? YES NO
- 45. Are you on a special diet? YES NO
- 46. Have you taken steroids within the last 3 months? YES NO
- 47. Do you wear contact lenses? YES NO
- 48. Have you ever taken Accutane? YES NO
- 49. Have you ever taken Bisphosphonates (Boniva, Fosamax, Actonel, Arredia, Zometa)? YES NO
- 50. Is there any history of Alcohol or Chemical Dependency or Emotional disorder? YES NO
- 51. Have you or any member of your immediate family had any problems associated with intravenous or general anesthesia? YES NO
- 52. Do you use marijuana, cocaine, or other "recreational" drugs? YES NO
- 53. List any other illnesses you have had _____ YES NO

Continued on next pg.

WOMEN ONLY

- 54. Are you pregnant, or is there any chance you may be pregnant? YES NO
- 55. Are you on birth control? YES NO
- 56. Are you breast feeding? YES NO
- 57. Date of your last menstrual cycle? _____ N/A

I understand the importance of a truthful and complete Health History and realize that my incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information provided is complete and accurate.

Signature / Date _____

LIST ALL MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING:

ADDITIONAL INFORMATION ABOUT YOUR CURRENT HEALTH:
