HISTORY AND PHYSICAL

Name: ____ Date: ____________________________

Social
Age: _______ Sex: M___ F___ Married: Y___ N___ Occupation: ____
Responsible adult available to assist during recovery period: Y ___ N ___ Relation: ___________________________

Habits
Smoke: Y___ N___ Amount: _____________________ Coffee/Tea/Cola: Y___ N___ Amount: ______________
Former Smoker: Y__ N__ Last date of use: ___________
Alcohol: Y___ N ___ Amount: ____________________ Daily Exercise: Y___ N___ Amount: _________________
Former alcohol use: Y__ N__ Last date of use: ________ Type of exercise: _______________________________

Medications: List dose or number of pills per day. Please list ALL MEDICATIONS including Adderall or other amphetamines, steroids, hormones (estrogen, testosterone, growth hormone)

Prescription Drugs	Non-Prescription Drugs (vitamins, herbs)
____	____
____	____
____	____
____	____

***ARE YOU CURRENTLY OR HAVE YOU BEEN ON ANY BIRTH CONTROL? Y_____ N_____ Last date of use: __________**
NUVA RING? Y___ N____ IUD? Y____ N____ Implanon? Y___ N_____ Other: _____________________________
Dosage & Frequency: ________________________

Regular Aspirin Use: Y___ N___ Dosage & Frequency: ____
NSA (Advil, Motrin, Ibuprofen) Y___ N___ Dosage & Frequency: ____
Cortisone Injections Past Year: Y___ N___ Dosage & Frequency: ____
Latex allergy: Y___ N___ Tape Allergy: Y___ N___ Drug Allergy: Y___ N___ List drugs and type of reaction:
____

Family History: Have any blood relatives ever had the following problems:

Abnormal bleeding:	Y___ N___	Coronary Surgery:	Y___ N___	Kidney Disease:	Y___ N___
Abnormal Clotting:	Y___ N___	Diabetes:	Y___ N___	Tuberculosis:	Y___ N___
Anesthetic Problems:	Y___ N___	Heart Attack:	Y___ N___	Other Serious Illness:	Y___ N___
Cancer:	Y___ N___	Hypertension:	Y___ N___		

Please describe questions with a “yes” answer: ____
____

Personal Past History: Have you ever had:

Abnormal bleeding:	Y___ N___	Asthma:	Y___ N___	Hypertension:	Y___ N___
Abnormal Clotting:	Y___ N___	Diabetes:	Y___ N___	Sleep Apnea:	Y___ N___
Acid Regurgitation:	Y___ N___	Fainting Spell:	Y___ N___	Snoring:	Y___ N___
Anemia:	Y___ N___	Heart Attack:	Y___ N___	Weight Change past 12 months	Y___ N___
Angina:	Y___ N___	Hepatitis:	Y___ N___	Other serious Illness:	Y___ N___
Cancer:	Y___ N___	Chemo/Radiation _________		Thyroid problem:	Y___ N___

Please describe questions with a “yes” answer____
____
Previous history of drug/alcohol abuse? ____

History of rehab/methadine clinic/suboxine clinic? ____
Have you ever received a transfusion? Y___ N___ If yes, what year? ____
Have you been tested for HIV? Y___ N___ If yes, what year? _________ Test results: Positive ___ Negative ___
Do you wear contact lenses? Y___ N___ Eye glasses? Y___ N___ Hearing aid? Y___N___ Dentures? Y___ N___

Previous surgery? Year and type of procedure: (Please include C-sections) ____
____
Indicate the type(s) of anesthesia received in the past, list any complications/reactions you experienced:
___local anesthesia: complications/reactions ____
___General anesthesia: complications/reactions ____
___Spinal/Epidural: complications/reactions ____

Primary Care Physician name: ____ Phone: ________________________
Address: ______________________________________ Date last seen by Primary Care Physician: __________________

Women Patients Only:
Number of pregnancies: ___ Number of children: ___ Last menstrual period: _____ Did you breast feed? Y___ N___

TO BE COMPLETED BY PHYSICIAN

Review of Systems	Y___ N___	Irregular Heart Beat	Y___ N___	Normal Menstrual Period	Y___ N___
Loose Dental Devices	Y___ N___	Vomiting	Y___ N___	Current Pregnancy	Y___ N___
Neck Mobility Problem	Y___ N___	Difficult voiding	Y___ N___	Cough	Y___ N___
Short Neck	Y___ N___	Seizure	Y___ N___	Shortness of Breath	Y___ N___
Chest Pain	Y___ N___	Obesity	Y___ N___	Black out	Y___ N___
Stroke	Y___ N___	Recent Upper Respiratory Infection	Y___ N___		

Comments: ____
____

Physical Exam
Height: __________ Weight: __________ Blood Pressure: __________ Pulse: __________ Temp: __________
General Status Comment
HEENT: _____________ Vision: _____________ Pharynx: ___________ Dental Device: _________________________
Pulmonary: ____
Heart: ____
Abdomen: ____
Extremity: ____
Neurologic (if applicable): ____
Comments: ____
Laboratory (if applicable)

H/H: _________________________	Potassium: ____________________	WBC: ____________________
PT: __________________________	BUN: _________________________	Chest X-Ray: ______________
Mammogram: _________________	EKG (pt over 40): _______________	CO_2: _______________________
Pregnancy Test: ________________	Sodium Chloride: _______________	Creatinine: _________________

Comments: ____
____

ASA CLASSIFICATION
□ P1 A normal healthy patient
□ P2 A patient with mild systemic disease
□ P3 A patient with severe systemic disease
□ P4 A patient with severe systemic disease that is a constant threat to life