HEALTH HISTORY

Patient Name _____ Height _____Weight _____

List any surgery you've had in the past: _____

Have you ever had any problems with anesthesia: YES □ NO □ If yes please explain: _____

List any medicines or drugs you have taken within the past year:

MEDICINE	DOSAGE	HOW OFTEN	MEDICINE	DOSAGE	HOW OFTEN

Are you in pain management? YES □ NO □

Have you had an **ALLERGIC** or unfavorable reaction to any food, medicine or drugs? YES □ NO □

(Please List) _____

	Have you had or do you currently have...	Y	N	Notes		Have you had or do you currently have...	Y	N	Notes
1	Cancer?				23	Frequent thirst or urination?			
2	Osteoporosis / Osteopenia?				24	Kidney trouble?			
3	Damaged heart valves/mitral valve prolapse?				25	Are you on dialysis?			
4	Heart murmur?				26	Swollen ankles, arthritis or joint disease?			
5	High blood pressure?				27	Stomach ulcers?			
6	Chest pain, angina?				28	Contagious diseases?			
7	Heart attack(s)?				29	Sexually transmitted diseases?			
8	Bronchitis, chronic cough, pneumonia?				30	Herbals or Supplements?			
9	Asthma, hay fever, or sinus problems?				31	Acne, facial scarring, skin blemishes?			
10	Tuberculosis?				32	Problems of the immune system?			
11	Difficulty breathing, emphysema?				33	Recent weight loss?			
12	Any other lung trouble?				34	Mental health problems/psychiatric treatment?			
13	Do you smoke?				35	Drugs (marijuana, cocaine)?			
14	Bruise easily?				36	Alcoholic beverages?			
15	Bleeding tendency (abnormal bleed?)				37	Eye disease/glaucoma			
16	Jaundice, hepatitis or liver disease?				38	Radiation therapy/chemotherapy?			
17	Frequent headaches?				39	Blood transfusion?			
18	Fainting spells?				40	Pain or clicking of jaws when eating?			
19	Convulsions, epilepsy?				41	Malignant hyperthermia?			
20	Stroke?				42	Are you pregnant?			
21	Thyroid trouble?				43	TMJ problems?			
22	Diabetes?				44	Snoring or sleep disturbance?			

Do you have any other medical or health problems which have not been mentioned above? □ Yes □ No If yes, Please describe:_____

FEES AND PAYMENTS:

We make every effort to keep down the cost of your surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office depending on special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on the patient information sheet.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance or any other balance not paid for by your insurance company.

This signature on file is my authorization for the release of private health information (PHI) necessary for the treatment, payment or health care operations. I hereby authorize payment directly to the provider named of the insurance benefits otherwise payable directly to me.

I understand that the Practice has a Notice of Privacy Practices and that I have the opportunity to review this Notice. I understand the Practice reserves the right to change the Notice of Privacy Policies. I have the right to restrict the use of my information but the Practice does not have to agree to those restrictions. I may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition treatment upon the execution of this Consent. I will allow photographs to be taken if needed that may be used for teaching purposes.

_____ _____

Signature Date