Dear Patient:
We welcome the opportunity to participate in your medical care. To ensure maximum safety and efficiency, we ask that you provide accurate answers to the questions asked relating to your general state of health. Thank you for your help and we look forward to caring for you.

Name: _____ Age: _____ Height: _____ Weight: _____

List all allergies:	List all medication you take now:	List all operations you have had:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of last period: _____ Have you ever had a pelvic exam? _____

Number of previous: pregnancies: _____ live births: _____ abortions: _____ still births: _____
miscarriages: _____

Anesthesia:			COMMENTS:
1. Have you had anything to eat, drink or smoke in the last 8 hours?	Y	N	_____
2. Have you ever had an anesthetic? LOCAL GENERAL	Y	N	_____
3. Have you ever had a problem with anesthesia?	Y	N	_____
4. Has anyone related to you ever had a problem with anesthesia?	Y	N	_____

Respiratory:			
1. Do you smoke? If yes, how many packs per day and for how many years?	Y	N	_____
2. Do you have a cough?	Y	N	_____
3. Do you bring anything up when you cough?	Y	N	_____
4. Have you had asthma? Last attack _____ Do you have an inhaler?	Y	N	_____
5. Do you have a cold? Are you taking any medications?	Y	N	_____
6. Have you ever had an abnormal chest x-ray?	Y	N	_____
7. Have you ever had difficulties breathing?	Y	N	_____
8. Are you ever short of breath at night?	Y	N	_____
9. Do you have a heart murmur? MVP?	Y	N	_____
10. Have you ever had a heart attack?	Y	N	_____
11. Have you ever had angina or pain in the chest related to your heart?	Y	N	_____
12. Have you ever had an abnormal EKG?	Y	N	_____
13. Have you ever had high blood pressure? With pregnancy?	Y	N	_____

Renal:			
1. Have you ever had kidney disease?	Y	N	_____
2. Have you ever been jaundiced?	Y	N	_____

GI:			
1. Have you ever had hepatitis?	Y	N	_____
2. Have you ever had a hiatal hernia or get heartburn?	Y	N	_____
3. Do you consume alcohol? If so, how much and how often?	Y	N	_____

(Questionnaire continued on reverse side)

Neurological: COMMENTS:

1. Have you ever had a stroke? Y N _____
2. Do you have an arm or leg that becomes numb? Y N _____
3. Have you ever had seizures, episodes of unconsciousness, or fainting? Y N _____
4. Have you ever had a problem with your vision? Y N _____
5. Do you wear contact lenses? Y N _____

Endocrine:

1. Do you have diabetes? Y N _____
2. Have you ever had thyroid problems? Y N _____

Musculoskeletal:

1. Do you have back problems? Y N _____
2. Do you have arthritis? Y N _____
3. Do you have any physical disabilities? Y N _____

General:

1. Do you have any bleeding tendencies? Y N _____
2. Have you ever been anemic? Y N _____
3. Have you used aspirin in the last two weeks? If so, how much? Y N _____
4. What birth control method(s) have you used? _____
   Any problems: _____
5. Do you have any of the following? (Circle) chipped/loose teeth dentures caps bridgework braces
6. Have you ever been in the care of a psychiatrist? Y N _____
7. Are you breast feeding? Y N _____
8. Have you ever had any blood clots in your lungs or legs? Y N _____
9. Have you ever used any street drugs? Y N _____
10. Have you ever had a sexually transmitted disease? Y N _____
11. Is there anything else you feel you should tell us? If yes, explain_____

_____

_____

Patient's Signature: _____Date:_____