HEALTH INFORMATION

Please answer all questions that relate to you, this form will be part of your record.

Patient's Name _____ Today's Date _____

1. Past Medical Illnesses. Please check appropriate responses.

   Do you have, or are you being treated for,

_____ YES	_____ NO	High Blood Pressure		_____ YES	_____ NO	Stomach Ulcers	
_____ YES	_____ NO	Heart Disease, Murmur		_____ YES	_____ NO	Nervous System Problems	
_____ YES	_____ NO	COPD, Emphysema, Lung Disease		_____ YES	_____ NO	Tuberculosis	
_____ YES	_____ NO	Bleeding Problems		_____ YES	_____ NO	Hepatitis or Liver Disease	
_____ YES	_____ NO	Diabetes		_____ YES	_____ NO	Cancer, type	

2. Other Medical Problems

_____

3. Operations You Have Had

_____

4. Personal/Family History of Anesthesia Problems(being put to sleep for surgery)YES___NO____

5. Personal/Family History of Bleeding Problems YES_____ NO_____

6. List ALL Medicines you are TAKING, and their DOSE. (if none write NONE)

_____

_____

7. List MEDICINES you are ALLERGIC to (If None write NONE)

_____

6. Have you taken Aspirin or Blood thinners in the past week _____ YES _____ NO
7. Do you smoke or use tobacco _____YES _____NO if YES, How Much _____
8. Do you drink alcohol _____YES _____NO if YES, How Much _____
9. Family History of Illnesses:

_____

_____