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HEALTH HISTORY SURVEY

Name: _____ Date: _____

List allergies: _____

List previous surgery and approximate dates: _____

List current medications: _____

Have you ever had general or twilight anesthesia?	No () Yes ()
Do you smoke? How many packs per day? _____	No () Yes ()
Do you have a chronic cough?	No () Yes ()
Do you have any breathing problems?	No () Yes ()
Have you had bronchitis, pleurisy, or pneumonia?	No () Yes ()
Have you had asthma?	No () Yes ()
Have you had a recent cold?	No () Yes ()
Have you ever had an abnormal chest x-ray?	No () Yes ()
Do you have problems with motion sickness?	No () Yes ()
Do you have any bleeding tendencies?	No () Yes ()
Have you ever been anemic?	No () Yes ()
Have you ever had a heart attack?	No () Yes ()
Have you ever had chest pain related to your heart?	No () Yes ()
Do you have a heart murmur or irregular beat?	No () Yes ()
Have you ever had high blood pressure?	No () Yes ()
Do you ever wake up at night short of breath?	No () Yes ()
Do you have diabetes?	No () Yes ()
Have you ever had thyroid problems?	No () Yes ()
Have you ever had a stroke?	No () Yes ()
Have you ever had epilepsy, seizures, or fainting spells?	No () Yes ()
Do you have frequent headaches or migraine?	No () Yes ()
Have you ever had eye problems or dry eye syndrome?	No () Yes ()

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