Access2Care
Family Medical Center
Olu Onisile, MD

Patient Health History

PAST HISTORY

Please indicate all illnesses and/or injuries:

❑ Heart Disease	❑ Stroke	❑ Gallbladder Disease	❑ Hepatitis
❑ High Blood Pressure	❑ Gout	❑ Cancer (DESCRIBE) _____	❑ Seizures
❑ Rheumatic Fever	❑ Pneumonia	❑ Bleeding Tendencies	❑ Kidney Dysfunction
❑ Heart Murmur	❑ Tuberculosis	❑ Thyroid Trouble (DESCRIBE) _____	❑ Blood Transfusions
❑ Enlarged Heart	❑ Pleurisy	❑ Kidney Stones	❑ Other _____
❑ High Cholesterol	❑ Hiatal Hernia/Reflux	❑ Phlebitis	❑ Other _____
❑ Diabetes	❑ Stomach Ulcer	❑ Sexually Transmitted Diseases	❑ Other _____

OPERATIONS

Please indicate all operations you have had and the dates:

❑ Tonsillectomy _____	❑ Sinus Surgery_____	❑ Hysterectomy_____
❑ Adenoidectomy _____	❑ Throat Surgery (OTHER THAN TONSILS) _____	❑ Appendectomy_____
❑ Tubes in Ears_____	❑ Heart Surgery_____	❑ Hernia Repair _____
❑ Other Ear Surgery_____	❑ Gallbladder _____	❑ Other_____
❑ Nose Surgery_____	❑ Blood Vessel Surgery_____	❑ Other_____

Have you ever had problems with anesthesia? ❑ Yes ❑ No

Have you ever been told you or a relative has malignant hyperthermia? ❑ Yes ❑ No

Have you ever been told you have a latex allergy? ❑ Yes ❑ No

MEDICATIONS

Current Medications including Aspirin, Vitamin Supplements, Herbs	Reason	Dose (How many mgms?)	Frequency (How often?)

ALLERGIES/REACTIONS TO MEDICATIONS, ANESTHETICS OR MATERIALS

LIST:

FAMILY HISTORY

❑ Do you have a family history of trouble with anesthesia? ❑ Yes ❑ No

❑ Do you have a family history of easy bleeding? ❑ Yes ❑ No

❑ Do you have a family history of allergy/asthma? ❑ Yes ❑ No

❑ Do you have a family history of diabetes? ❑ Yes ❑ No

❑ Do you have a family history of cancer? ❑ Yes ❑ No

❑ Do you have a family history of heart disease? ❑ Yes ❑ No

❑ Do you have a family history of any other diseases? ❑ Yes ❑ No

(DESCRIBE)_____

SOCIAL HISTORY

Do you use tobacco? ❑ Yes, I've smoked _____ packs of cigarettes per day for _____ years ❑ Yes, I smoke cigars or a pipe ❑ Yes, I use snuff/chew

❑ No, I have never smoked ❑ No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

❑ Does anyone in the family smoke? Who? _____

Do you drink alcohol? ❑ Yes ❑ No, never (or rarely) ❑ No, but I used to If yes, what and how much? _____

Were you ever a heavy drinker? If yes, what and how much? _____

Children: Number of children: _____ Daycare: ❑ Yes ❑ No Number of days per week _____

Regular exercise: ❑ Yes ❑ No What type? _____ How often? _____

Work in a noisy environment? ❑ Yes ❑ No Do you wear hearing protection? ❑ Yes ❑ No What type? _____

Do you own hearing aids? ❑ Yes ❑ No How long? _____ Do you wear them? _____

The above information is accurate to the best of my knowledge.

Patient / Guardian Signature Date