

An Artist's Eye. A Woman's Touch

HEALTH HISTORY (Page 1)

Please answer all questions fully and honestly. All information is confidential.

Patient Name:

Date of Birth: ____/____/____

Age ____ Sex: M F HEIGHT ____ WEIGHT ____

Family Physician _____ Date of last exam _____

LIST MEDICATIONS AND REASON, INCLUDING OVER-THE COUNTER DRUGS & VITAMINS:

MEDICATIONS

REASON

<u>MEDICATIONS</u>	<u>REASON</u>

ALLERGIES/DRUG SENSITIVITIES:

Previous operations and/or hospitalizations and dates: _____

Have you or any family member ever had problems from anesthesia? Yes No

If yes, explain: _____

HAVE YOU EVER HAD:

Yes

No

Explain

Anemia	_____	_____	_____
Abnormal bleeding	_____	_____	_____
Emphysema, Asthma	_____	_____	_____
Drug/Alcohol dependence	_____	_____	_____
Kidney disease	_____	_____	_____
Birth defects	_____	_____	_____
Hepatitis/Jaundice	_____	_____	_____
Cirrhosis	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____
High blood pressure	_____	_____	_____
HIV testing	_____	_____	_____
Stroke	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid problems	_____	_____	_____
Heart attack/murmurs	_____	_____	_____
Chest pain	_____	_____	_____
Rheumatic heart disease	_____	_____	_____
Serious injuries	_____	_____	_____

HEALTH HISTORY (Page 2)

Patient Name: _____

Date of Birth: ____/____/____

HAVE ANY BLOOD RELATIVES HAD:

	YES	NO	RELATIONSHIP
Stroke	_____	_____	_____
Cancer	_____	_____	_____
High blood pressure	_____	_____	_____
Diabetes	_____	_____	_____
Rheumatic heart	_____	_____	_____
Congenital heart	_____	_____	_____
High fever after surgery	_____	_____	_____
Epilepsy	_____	_____	_____
Asthma	_____	_____	_____
Bleeding tendency	_____	_____	_____
Heart attack	_____	_____	_____
Kidney disease	_____	_____	_____
Arthritis	_____	_____	_____

Do you smoke? _____ If yes, how much? _____

Do you use illicit drugs? _____ If yes, how often? _____

Do you drink alcohol? _____ If yes, how often? _____

Do you wear dentures? _____

Do you wear contact lenses? _____

PRESENT GENERAL HEALTH: Excellent Good Fair Poor

WOMEN:

Number of pregnancies: _____ Have you ever breast fed? _____

Are you pregnant now? _____ Date of last menstrual period _____

Are you breast feeding now? _____ Date of last mammogram _____

Date of last dental appt.: _____ Date of last pap smear: _____

I hereby certify that all of the above information is correct.

PATIENT _____

DATE _____

NURSE _____

DATE _____

DISCLOSURE TO FAMILY/FRIENDS

Patient Name (Print)

____/____/____
DOB

_____ **I DO NOT** want Marcia V. Ormsby, MD PC (“Provider”) to disclosure any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

_____	_____
_____	_____
_____	_____
_____	_____

The authorizations provided for above are subject to the following limitations or restrictions:

Signature of Patient (or legally responsible individual)

Date

Witness

Date