Patient Name

Health History

Circle YES or NO for all illnesses/ conditions/ disorders that apply to you (the patient) now or in the past

Illness	Currently		Previously		Explain or Describe
Asthma/Bronchitis/Emphysema	YES	NO	YES	NO	
Back Injury/Arthritis	YES	NO	YES	NO	
Cancer: (type_____________)	YES	NO	YES	NO	
Cataracts	YES	NO	YES	NO	
Diabetes	YES	NO	YES	NO	
Eating Disorder	YES	NO	YES	NO	
Hayfever	YES	NO	YES	NO	
Heart attack/angina	YES	NO	YES	NO	
Heart valve or rhythm problem	YES	NO	YES	NO	
High Blood Pressure	YES	NO	YES	NO	
Immune disorder (type_______________)	YES	NO	YES	NO	
Kidney Disease / Stones	YES	NO	YES	NO	
Liver Disease/Hepatitis	YES	NO	YES	NO	
Neurologic Disease / Stroke	YES	NO	YES	NO	
Psychiatric disease or depression	YES	NO	YES	NO	
Thyroid Disease	YES	NO	YES	NO	
Ulcers	YES	NO	YES	NO	
Vascular Disease/blood clots	YES	NO	YES	NO	

List any other disease or conditon you are currently being treated for:

What is your height: ____________ and approximate weight ___________.

Do you take antibiotics before going to the Dentist? YES or NO If yes—why?__________

Do you have a problem with unusual bruising or bleeding? YES or NO

Have you ever been physically asaulted or violated? YES or NO

Do you smoke? Never / Quit smoking in ________. Years smoked____. Lifetime of smoking ____packs/day.

Do you drink? YES or NO (If yes, number of drinks in a typical week ______)

Have you had a problem with alcohol or drug use? YES or NO

Do you exercise regularly? YES or NO If yes, what activity ____________________and how frequently___________.

Other hospitalization /serious illness /trauma not previously mentioned: **Date (Month/Year)**

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____
Patient Name

Surgical History

Operation	Month/Year	Reason	Where was the surgery done?

Allergies: (List any allergy to medications.) YES NO (If yes, describe your reaction.)

____

____

Have you ever had an allergic reaction to iodine? Shellfish? or Imaging contrast? (If yes, describe your reaction.)

____

Are you allergic to Latex? YES / NO (If yes, describe your reaction.) _______________________

Family History--Has anyone in your family had problems with: If yes, parent, sibling, grandparent or other.

			If yes, parent, sibling, grandparent or other.
Diabetes	YES	NO	
Heart Disease	YES	NO	
High Blood Pressure	YES	NO	
Urinary Tract	YES	NO	
Kidney stones	YES	NO	
Urologic or Gynecologic cancers	YES	NO	
Urinary infections	YES	NO	

Please list your current medications below:

Include presciption and over the counter medications, along with medications taken "as needed".

Medication & Dosage	Frequency	As Needed	Over the Counter