ANESTHESIA & PAIN MANAGEMENT SERVICES, P.C.
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PATIENT INFORMATION

LAST NAME ___________________________ FIRST NAME ____________________ MIDDLE INITIAL _____

SEX: MALE ☐ FEMALE ☐ DATE OF BIRTH ___/____/____ AGE_____ SSN#_________-_________-________

ADDRESS________________________________ CITY____________________ STATE_____ ZIP___________

HOME PHONE _______-________-________ BUSINESS PHONE _______-________-________ EXT._______

EMPLOYER NAME:____

ADDRESS________________________________ CITY____________________ STATE_____ ZIP___________

REFERRED BY____

PHYSICIAN____ PHONE NUMBER _______-________-________

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

SPOUSE'S NAME____

SPOUSE'S EMPLOYER____PHONE _______-________-________

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? ☐ SELF ☐ SPOUSE ☐ MOTHER ☐ FATHER ☐ OTHER

PARENT/GUARDIAN INFORMATION (IF MINOR)

FATHER'S NAME____ SSN#_________-_________-________

ADDRESS________________________________ CITY_____________________ STATE_____ ZIP___________

EMPLOYER NAME ____ PHONE_______-________-________

MOTHER'S NAME____ SSN#_________-_________-________

ADDRESS________________________________ CITY_____________________ STATE_____ ZIP___________

EMPLOYER NAME ____ PHONE_______-________-________

 PHH0507

PATIENT NAME_____________________________ DATE OF BIRTH _______________________________

HEALTH PROBLEMS OR MEDICATIONS THAT YOU MAY BE TAKING COULD HAVE AN IMPORTANT EFFECT ON THE CARE YOU WILL BE RECEIVING. PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE. ALL INFORMATION THAT YOU PROVIDE US WITH WILL REMAIN CONFIDENTIAL.

HEALTH HISTORY

ARE YOU IN GOOD HEALTH?___________________HEIGHT________________WEIGHT_______________
HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH IN THE PAST 5 YEARS YES NO
ARE YOU UNDER THE CARE OF A PHYSICIAN NOW YES NO IF YES, WHO ___________________
IF YES, WHAT ARE YOU BEING TREATED FOR____
HAVE YOU HAD ANY ILLNESS, OPERATION, OR BEEN HOSPITALIZED IN THE PAST 5 YEARS:
____
HAVE YOU EVER HAD A REACTION TO LOCAL ANESTHESIA (i.e. Novocain) YES NO
IF YES, PLEASE DESCRIBE:____
HAVE YOU EVER HAD A REACTION TO GENERAL ANESTHESIA YES NO
IF YES, PLEASE DESCRIBE:____
DO YOU SMOKE YES NO IF YES, HOW MANY PER DAY ___________________________________
DO YOU DRINK YES NO IF YES, HOW MANY DRINKS PER DAY___________________________

HAVE YOU HAD OR DO YOU CURRENTLY HAVE (ANY OF THE FOLLOWING?) **	YES	NO	DON"T KNOW	**HAVE YOU HAD OR DO YOU CURRENTLY HAVE (ANY OF THE FOLLOWING?) ****	YES	NO	DON"T KNOW
ASTHMA				KIDNEY TROUBLE			
BRONCHITIS OR CHRONIC COUGHING				INFECTIOUS MONONUCLEOSIS			
ANY OTHER LUNG TROUBLE				GALL BLADDER TROUBLE			
HEART MURMUR				ARTHRITIS / JOINT DENEGRATION			
RHEUMATIC FEVER				ARTIFICIAL JOINTS			
ABNORMAL HEART VALVE				CHRONIC ANXIETY / DEPRESSION			
CHEST PAIN, ANGINA				GASTRIC REFLUX			
CARDIAC PACEMAKER				STOMACH ULCERS			
HEART SURGERY				SEXUALLY TRANSMITTED DISEASES			
HEART ATTACK				AIDS / HIV			
IRREGULAR HEART BEAT				IMMUNE SYSTEM DISORDER			
ABNORMAL BLOOD PRESSURE				CANCER			
STROKE				RADIATION / CHEMOTHERAPY			
FAINTING SPELLS				EYE DISEASE / GLAUCOMA			
ANEMIA				WEAR CONTACTS/ GLASSES			
BRUISE EASILY / ABNORMAL BLEEDING				MENTAL HEALTH PROBLEMS			
HAYFEVER / SINUS TROUBLE				JAWS CLICK / LOCK			
DIABETES				MALIGNANT HYPERTHERMIA			
TUBERCULOSIS				JAUNDICE HEPATITIS			
THYROID TROUBLE				LIVER DISEASE			
CONVULSIONS / EPILEPSY				OTHER (DESCRIBE BELOW)			

** PLEASE DESCRIBE ____
____
____

MEDICATIONS

PLEASE LIST ANY MEDICATIONS YOU ARE NOW TAKING BELOW:

	MEDICATION	DOSAGE	HOW OFTEN
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

ALLERGIES

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING:

	YES	NO
LOCAL ANESTHETICS……………………………………………..………	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS…………………………………….	☐	☐
SULFA DRUGS………………………………………………………………..	☐	☐
BARBITURATES, SEDATIVES, SLEEPING PILLS………………………...	☐	☐
ASPIRIN………………………………………………………………………..	☐	☐
IODINE…………………………………………………………………………	☐	☐
CODEINE OR OTHER NARCOTICS………………………………………	☐	☐
OTHER MEDICATIONS……………………………………………………	☐	☐

ALLERGIES OTHER THAN DRUGS (FOOD, LATEX, ETC.) ____________________________________

____

CHILDREN ONLY

	YES	NO
ARE IMMUNIZATIONS CURRENT……………………..…………………….	☐	☐
HAS YOUR CHILD SEEN A FAMILY PHYSICIAN OR PEDIATRICIAN…………………………………………..……………….	☐	☐

IF SO WHEN WAS THE LAST VISIT ____

WOMEN ONLY

	YES	NO
IS THERE ANY POSSIBLITY YOU MAY BE OR ARE GOING TO BECOME PREGNANT……………………………………..	☐	☐

DATE OF LAST MENSTRUAL PERIOD ___________________________

	YES	NO
ARE YOU NURSING………………………………………………………..	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS………………………………	☐	☐

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I WILL NOT HOLD ANY MEMBER OF THIS STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE DURING THE COMPLETION OF THIS FORM.

DATE______/_______/_______ SIGNATURE OF PATIENT OR LEGAL GUARDIAN_______________________________