

(patient information)

Choice
Medical Group

HEALTH HISTORY

In order for us to provide you with the best medical care possible, it is necessary for us to have your complete medical history. Please fill out this questionnaire as accurately as possible. For YES / NO questions, please circle your answer.

Do you consider yourself to be in good health? YES NO If no, please explain why not: _____

Have you ever been hospitalized? YES NO If yes, give date and reason: _____

Do you have plans to travel in the next 2 weeks? YES NO If yes, when / to where? _____

Have you, or anyone in your family, ever had any problems with general anesthesia? YES NO

Do you know if your blood type is positive or negative? Positive Negative I don't know

Are you in an unsafe or abusive relationship? YES NO

Please list any medications you are currently taking, or have taken in the last 6 months (including over-the-counter medications, herbal supplements, and vitamins): _____

Are you allergic to any of the following?:

- doxycycline / tetracycline penicillin
- novocaine iodine latex
- other medication:
- foods or other substances:

Have you ever had any of the following?: (check all that apply)

- Anemia
- Asthma
- Autoimmune disorder
- Bleeding/clotting disorder
- Bronchitis or other lung/breathing problems
- Cancer
- Depression
- Diabetes: on insulin on oral medication diet-controlled
- Disease/disorder of the uterus or ovaries (fibroids, PID, etc)
- Epilepsy, convulsions, seizures
- Heart condition of any kind
- Hepatitis or other liver disease/disorder
- High blood pressure
- HIV/AIDS
- Hyperthyroid (overactive thyroid gland)
- Malignant hyperthermia
- Renal disease/disorder
- Sexually transmitted disease
- Sickle cell anemia: disorder trait only
- Sleep apnea
- Tuberculosis or positive TB skin test
- Other medical condition/disease/disorder: _____

Pre-procedure
clinician review
Initials: _____
Date: _____

Please list your total number of: (if applicable)

- Pregnancies, including this one _____
- Vaginal deliveries _____
- C-section deliveries _____
- Stillbirths _____
- Miscarriages _____
- Ectopic/tubal pregnancies _____
- Abortions _____
- Molar pregnancies _____

When was the first day of your last menstrual period?: _____

Would you consider it a normal period? YES NO

Have you had any bleeding or significant spotting since your last period? YES NO

If so, have you had any significant pain, on one side or the other, in your lower abdomen? YES NO

Have you used hormonal birth control in the last 3 months? YES NO

Are you breastfeeding currently? YES NO

The information below is a part of your complete, confidential medical care. Some medications we use can be dangerous if mixed with recreational drugs.

Have you used any of the following?:

| | Last use? | How often/how long used? |
|--------------|-----------|--------------------------|
| Alcohol | _____ | _____ |
| Marijuana | _____ | _____ |
| Cocaine | _____ | _____ |
| Heroin | _____ | _____ |
| Amphetamines | _____ | _____ |

(meth, speed, crank)
Have you ever injected drugs into a vein (IV)? YES NO
Other recreational drugs used: