AOW
Mobile Anesthesia

PATIENT HEALTH HISTORY QUESTIONNAIRE

NAME:______________________________ DATE OF BIRTH:____________ AGE:________ M or F (Circle One)

Please list any medications you are currently taking:____

____

____

Please ☑
YES/NO

☐ ☐ Have you ever had anesthesia? If yes, were there any complications with previous anesthesia treatment? Please explain.____

☐ ☐ Do you have any allergies? (Drugs, foods, latex, other)______________________________

☐ ☐ Are you in good health?

☐ ☐ Are you pregnant? If yes, number of months:_________

☐ ☐ Are you under the care of a physician? For what purpose?___________________________

☐ ☐ Have you had any serious illness, operation or hospitalization in the past 5 years?
If yes, for what? ____

☐ ☐ Do you bleed or bruise easily or have you had abnormal bleeding with previous treatment?

☐ ☐ Do you have any bleeding disorders? (i.e. Anemia, Sickle cell, prolonged bleeding)

☐ ☐ Do you use tobacco, chew or marijuana?
If yes, how much/often?____

☐ ☐ Do you use drugs or narcotics?

☐ ☐ Do you have artificial joints (hip, knee, elbow) or artificial heart valves?

☐ ☐ Do you have a heart pacemaker?

☐ ☐ Have you had surgery or radiation treatment for a tumor or growth of the head or neck?

☐ ☐ Have you ever had any serious trouble associated with any previous dental treatment, surgery or anesthetic? If yes, explain:____

☐ ☐ Has anyone in your family had a bad reaction to a previous anesthetic?

☐ ☐ Do you wear contact lenses?

☐ ☐ Do you have any of the following respiratory diseases or problems?

Asthma	Bronchitis	Pneumonia	Emphysema	Tuberculosis (TB)
Hay Fever	Chronic Cough	Sinus Trouble	Allergies	

☐ ☐ Do you currently have a cold or flu?

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

Diabetes	Arthritis/Rheumatism	Hepatitis/Liver Problems	Ulcers
Sleep Apnea	Persistent Diarrhea	Thyroid problems	Reflux/GERD
Asthma	Chest Pain/Stroke	High/Low Blood Pressure	Jaundice
Tuberculosis	Sinus Trouble	Seizures/Fainting/Epilepsy	Kidney Problems
Cerebral Palsy	Psychiatric Problems	Cancer/Chemo/Radiation	Spastic Paralysis
AIDS/HIV	Down Syndrome	Compromised Immune System	

Do you have any disease, conditions or problems not already mentioned above? If yes, explain:

____

____

I understand that withholding ANY information could seriously jeopardize the safety of my health (or for your child if you are a Parent/Guardian). I have reviewed this health history carefully and have answered all questions truthfully to the best of my knowledge.

______________________________	______________________________
Name of Person Signing	Relationship to Patient
______________________________	______________________________
Signature	Date