A.H. Ahmadi, MD. PLLC

Health History

Name_____ Date_____Age _____Height_____Weight_____Sex: M F Primary Physician_____

List all medical problems:	List all medications (including herbals, diet):	List all surgeries/procedures and dates (including cosmetic):
…….....	…….....	…….....
……	……	……..……..……
……	……	……..……
……	……	……..……
……	……	……..……
……	……	……..……
……	……	……..……

	YES	NO	
Have you or a family member ever had a problem with an anesthetic other than nausea?	☐	☐	
Do you have difficulty swallowing pills?	☐	☐	
Have you had problems with prior surgeries/procedures?	☐	☐	Explain?…….....
Do you have any allergies (drug, Latex, tape, dye)?.	☐	☐	List?…….....
Have you ever or do you now smoke?…….……	☐	☐	How much and for how long?.....
Do you have a cold, cough or have any breathing difficulty?	☐	☐	
Do you have asthma?	☐	☐	What induces it? When was your last episode?…
Do you have sleep apnea?	☐	☐	
Do you have high blood pressure?	☐	☐	For how long?.....
Do you have a heart murmur? Mitral valve prolapse?	☐	☐	
Have you ever had an abnormal EKG?	☐	☐	
Have you ever had angina or a heart attack?	☐	☐	
Do you ever wake up short of breath or have swelling over your shins?	☐	☐	
Do you have difficulty walking up two flights of stairs without becoming short of breath?	☐	☐	
Do you have "hardening of your arteries"?	☐	☐	
Have you ever had kidney disease or require a special diet due to your kidneys?	☐	☐	
Have you ever had hepatitis or been jaundiced?	☐	☐	
Do you have HIV or Hep C ?	☐	☐	
Do you have a hiatal hernia, acid reflux, or an ulcer?	☐	☐	
Do you drink alcohol?	☐	☐	How much and how often?.....
Have you ever had a stroke?	☐	☐	
Do you have a limb that becomes weak or numb?	☐	☐	
Have you ever had seizures, loss of vision or speech?	☐	☐	
Do you have diabetes?	☐	☐	Do you take ☐ insulin or ☐ pills?
Do you have thyroid disease?	☐	☐	
Do you have back, neck, or jaw problems?	☐	☐	
Do you have any bleeding disorders?	☐	☐	
Do you have anemia (low blood count)?	☐	☐	
Have you taken aspirin, coumadin, Plavix or Lovenox in the last week?	☐	☐	
Have you taken any diet medications in the last month?	☐	☐	
Have you had any disease requiring chemotherapy or radiotherapy?	☐	☐	
Do you have children?	☐	☐	Ages?……..
Is there any chance you could be pregnant?.	☐	☐	Date of last period?……..……
Are you planning to become pregnant in the future?	☐	☐	
Have you or a family member had breast cancer?	☐	☐	Relationship?……..……
Have you had a mammogram?	☐	☐	Date?.....Result?.....……
Have you ever used illicit drugs?	☐	☐	List?……
Do you get cold sore/fever blisters?	☐	☐	
Do you have vaginal herpes?	☐	☐	
Have you taken Accutane in the past year?	☐	☐	
Have you been treated for attention deficit disorder, depression, anxiety, obsessive compulsive disorder, bipolar disorder, or schizophrenia?	☐	☐	Treating physician?……..……
Do you have any other medical or psychiatric problems not listed already?	☐	☐	List:……..……..

Patient/Guardian Signature _____

Wt ……BMI ……Bra Size & Cup……..…Tests/Studies/Clearance……..……Price……

Procedure(s):……..……..OR Block Time: 1/3 1/2 2/3 1

Second Procedure(s):……Overnight (None/Local)