LUXE ANESTHESIA

Adult Health History Form

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Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____ City: _____ State: _____ ZIP: _____

Cell: _____ Home: _____ Gender: _____

Treating Dentist: _____ Email: _____

Do you have any ALLERGIES (include foods)? _____

What MEDICATIONS do you take? _____

Is your overall health excellent, good, fair or poor? _____ Do you exercise? _____

List ALL physicians' names, phone numbers and specialties. _____

List all previous surgeries or hospitalizations. _____

Check ALL that apply	**YES**	**NO**
1) History of chest pain, heart failure, stents, coronary disease, palpitations heart attack, heart murmur, pacemaker, defibrillator, arrhythmia, stroke, malfunctioning heart valves, SVT, VT, cardiac arrest, cardiomyopathy? _____	☐	☐
2) History of high blood pressure, carotid stenosis, syncope/fainting, shortness of breath on exertion, cyanosis, Raynauds, vascular disease? _____	☐	☐
3) Do you have asthma, COPD, chronic bronchitis, emphysema, bronchotracheomalacia, sarcoidosis, restrictive lung disease, cyanosis, recent pneumonia? Do you require oxygen? _____	☐	☐
4) Do you have diabetes or thyroid abnormalities? Any other endocrine issues? _____ Most recent A1C: _____	☐	☐
5) Do you snore loudly at night or do you have obstructive sleep apnea? History of sleep study? _____	☐	☐
6) Do you have liver disease or any bleeding or clotting disorders? _____	☐	☐
7) Do you have history of kidney disease? Are you on dialysis? _____	☐	☐
8) Have you taken steroids for greater than 2 weeks in the past 2 years? _____	☐	☐
9) Do you have history of seizures, Alzheimers, Parkinson's, or other neurological disorders? _____	☐	☐
10) Do you have muscular dystrophy, hypotonia, rhabdomyolysis, or other muscular disorders? _____	☐	☐
11) Do you or a family member have a history of malignant hyperthermia or pseudocholinesterase deficiency?	☐	☐
12) Do you have any syndromes, genetic disorders, or special needs? _____	☐	☐
13) Do you have autism, ADHD, intellectual disability, anxiety, depression, or other mental health concerns?	☐	☐
14) Do you have a history of cancer? Radiation to head and neck? _____	☐	☐
15) Have you ever smoked? How many packs per day? _____ How many years? _____ Year quit? _____	☐	☐
16) Do you drink alcohol? How many drinks per day/week? _____	☐	☐
17) Do you have a history of substance abuse or infectious disease? _____	☐	☐
18) Are you pregnant or breastfeeding?	☐	☐
19) Do you have anemia or sickle cell trait or sickle cell disease? _____	☐	☐
20) Do you have any autoimmune disorders such as rheumatoid arthritis? _____	☐	☐
21) Please list and describe ANY health conditions or concerns not listed above: _____		

I have reviewed the above medical health history completely and have answered all questions truthfully and to the best of my knowledge. I understand withholding information about my health could pose risks to my safety. I hereby give permission to Luxe Anesthesia Services to discuss my medical health with other health professionals and consent to the release of medical records for the purpose of obtaining medical consultations.

Patient Name: _____ Signature: _____ Date: _____