ADULT HEALTH HISTORY FOR DR. THERESA PHAM

Patient's Name: _____ Sex: _____ DOB: _____

Address: _____

City: _____ Zip: _____

Height: _____ Weight: _____

Phone #: _____ Email: _____

Name of Primary Doctor/Phone: _____

CIRCLE YES or NO as to the presence of history of the following conditions:

Recent Cold	NO	YES	Sleep Apnea	NO	YES
Asthma	NO	YES	Hypertension	NO	YES
Emphysema	NO	YES	Heart Attack	NO	YES
Diabetes	NO	YES	Irregular Heart Beat	NO	YES
Pregnant?	NO	YES	Chest Pain	NO	YES
Peptic Ulcer/Reflux	NO	YES	Back Trouble	NO	YES
Abnormal Bleeding	NO	YES	Stroke	NO	YES
Dentures	NO	YES	Alcohol/Drug Abuse	NO	YES
Tobacco Use	NO	YES	Regular Exercise?	NO	YES
Broken Bones	NO	YES/Location? _____			

Personal or Family History of Anesthesia Problems? _____
When was your last electrocardiogram (EKG) done? _____
Have you ever been told you have an **ABNORMAL EKG?** YES/NO
Please explain: _____
Any other medical problems? _____

Allergies: _____

Current Medications: _____
_____

Prior Surgeries (Give Approx. Dates): _____
_____

Signature_____ Date: _____
Circle One: Patient/Parent/Guardian
[For Dr. Pham only: Reviewed _____ Date: _____]