SOBA
Southern Office-Based Anesthesia

Southern Office-Based Anesthesia
PO Box 2656 Henderson, NC
Phone: (252) 213-8484
FAX (252) 359-3454

ADULT MEDICAL HISTORY FORM

Patient's Name: ______________________ Date of Birth: _____/_____/____ Age: _____ Weight: ______lb

Address: ______________________ City: ______________ State: _____ Zip: ___________

Treating Dentist: ______________________ Gender: ________

Date of Surgery: ______________________ Home: (___) ________________ Cell: (___) ________________

List all **medications** and dosages currently being taken (**include vitamins, herbs, over-the-counter pills**):
____

Do you have **allergies to any medications or foods**? If yes, list and state what happened? ____________________________

1. Are you in good health? ______________________ Yes No
2. Are you currently or regularly under the care of a physician? Name ______________ Yes No
   Phone ______________
   A. Do you see a specialist? If yes, please list with phone #: ______________ Yes No
3. Have you ever had anesthesia for a surgical procedure? ______________ Yes No
4. Have you had any serious illnesses, accidents, operations, or been hospitalized in the last 5 years? ______________ Yes No
   Please list: ______________
5. Do you have or have you had in the past any of the following heart diseases or complications? ______________ Yes No
   Circle all that apply: Heart Attack, Murmurs, Malfunctioning heart valves, Pacemaker/Defibrillator, Arrhythmias or irregular heartbeat, Cardiac arrest?
6. Do you have or have you had in the past any of the following cardiovascular (heart) complications? ______________ Yes No
   Circle all that apply: Chest pain or cyanosis upon exertion, Shortness of breath on exertion High blood pressure, Stroke, Recurrent Fainting, Palpitations
7. Have you had had a recent runny nose, cough, cold, fever, or flu? ______________ Yes No
   How long has it been fully resolved? ________ (days / weeks)
8. Do you have or have you had in the past any of the following lung diseases or complications? ______________ Yes No
   Circle all that apply: Bronchitis, pneumonia, Chronic cough, Chronic sinus disease, Seasonal allergies
9. Are you pregnant? ______________ Yes No
10. Have you been diagnosed with Sleep apnea or is there loud snoring every night when sleeping? ______________ Yes No
11. Do you have or have you had in the past any of the following diseases or complications? ______________ Yes No
    - Liver (Hepatitis, jaundice)? ______________ Yes No
    - Kidney (Kidney stones, Ureter or Bladder disorders, Renal insufficiency or failure)? ______________ Yes No
    - Thyroid Disease or Diabetes? ______________ Yes No
    - Stomach Problems (ulcers, excess stomach acid, or reflux, persistent diarrhea, weight loss)? ______________ Yes No
    - Arthritis (swollen or painful joints or lymph nodes)? ______________ Yes No
    - Muscle disorders or weakness (Low muscle tone, muscular dystrophy)? ______________ Yes No
    - Seizures, Fainting Spells, Frequent Headaches, or other neurological problems? ______________ Yes No
    - Intellectually challenged, Depression, ADHD, Autism, PDD, or any other problems with mental health? _____ Yes No
    - Cancer, Sexually transmitted diseases, HIV, AIDS? ______________ Yes No
12. Do you smoke tobacco? ______________ Yes No
13. Do you consume alcoholic beverages? ______________ Yes No
    A. If yes, how many drinks per week? ______________
14. Do you use or have a history of illicit or recreational drug use/abuse? ______________ Yes No
15. Do you bruise easily or have you ever been diagnosed with a bleeding disorder? ______________ Yes No
16. Do you have any blood disorders such as Anemia or Sickle Cell Anemia? ______________ Yes No
17. Have any of your blood relatives ever had a bad or unusual reaction to anesthesia? ______________ Yes No
18. Do you have any disease, disorder, or complication not mentioned above? ______________ Yes No
    If yes, please explain: ____
    ____

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge. I hereby give permission to Southern Office-Based Anesthesia to discuss my medical health with other health professionals involved with my care.

Patient Signature: ______________________ **Printed Name:** ______________________ **Date:** ___/___/___