

Part III: Allergies

Do you have any allergies to foods or medications? Yes No

If yes, please explain below. Include the reaction you had, and any treatment that was required.

Part IV: Anesthesia history

Have you ever had a problem with:

- Iodine:..... Yes No
- Valium-type drugs:..... Yes No
- General anesthesia / sedation: Yes No
- Bleeding after surgery or dental work: Yes No

Do you currently have a problem with:

- Lying flat:..... Yes No
- Head, neck, or back pain:..... Yes No
- Loose teeth or dentures?..... Yes No
- Difficulty breathing through your nose: Yes No

Please describe any other any other problems that you have had during surgery or dental procedures.

Part V: Hospitalizations and/or Major Illnesses

Reason for hospitalization / illness	Date(s)	Hospital name

Part VI: Family History

	Age(s)	Living/Deceased	Major illnesses or cause of death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

Has anyone in your family ever had:

WPW Yes No Unexpected death Yes No Passing out/seizures (epilepsy) Yes No

Comments:

Part VIII: Habits

	Do you currently?	Have you ever?	If yes, how much / for how long?	If you stopped, when?
Smoking				
Alcohol				
Caffeinated foods / drinks*				
Illegal drugs (specify)				
Stressful lifestyle				

*such as coffee, tea, cola drinks, chocolate

Please do not write below this line.

**Reviewer's
signature:**

Date:
