



**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:**

\_\_\_\_\_