Confidential Personal History

Date : ____________________________

Name (Last name, first name):____

Parents Names (if patient is a child) : ______________________________________

Date of Birth (DD/MM/YY): ___/_____/_____Age:_______ Sex: ______Weight:_____

Health Card: Number : ____________________________Letters (if any): _______

Markham Stouffville Hospital ID # (if known):_______________________________

Telephone Number: Home (______) _____________ Work (_____) ____________

Cell (_____) _______________

Home Address: ____

____________________________Postal Code _________________

Occupation(if adult):____

Doctor who referred you:

____

Family Doctor (if not referring physician) ________________________________

Number one problem here to see doctor about: _________________________________

Other problems you would like to ask the doctor about : __________________________

List all current medications and dosages and frequency taken :

____

____

____

____

List all allergies:

Medication allergies ____

____

Other allergies ____

Have you ever had allergy tests ? YES / NO If yes, when ? _______________

****Please turn over .**

Have you ever smoked? Yes ☐ No ☐

If yes then answer the following:

Are you currently smoking : Yes ☐ No ☐ Amount _______ packs/day

Total number of years smoked: _______

If quit, How long ago : ______________

Estimate the amount of alcohol per week: ______ Beer ______Wine _______oz liquor

Please answer the following questions to the best of your ability - if you answer yes please explain.

1. Have you ever had any heart troubles? YES ( ) NO ( ) ______________________
2. Do you have high blood pressure ? YES ( ) NO ( ) ______________________
3. Do you have asthma/Bronchitis/emphysema? YES ( ) NO ( ) _________________
4. Do you have diabetes? YES ( ) NO ( ) ___________________________________
5. Could you be pregnant? YES ( ) NO ( ) __________________________________
6. Do you have rheumatoid arthritis? YES ( ) NO ( ) __________________________
7. Do you have any stomach problems or ulcers? YES ( ) NO ( ) ________________
8. Have you taken any oral steroid drugs in the last year (not puffer) ? YES ( ) NO ( )

9. Do you need antibiotics before dental work? YES ( ) NO ( ) __________________

10. Have you or a member of your family had a problem with an anaesthetic (i.e. malignant hyperthermia) ?YES ( ) NO ( ) ____________________________

11. Have you ever been diagnosed or suspected to have sleep apnea? YES ( ) NO ( )

12. Have you been diagnosed as MRSA or VRE positive? YES ( ) NO ( )_________

13. Are you Hepatitis B or C positive ? YES ( ) NO ( ) ________________________

12..Describe any other current medical problems: _______________________________

____

13. List previous operations and dates (if related) ______________________________

____

14. List previous illnesses: ____

____