PAST HEALTH HISTORY:

Is your visit with Dr. Norris due to a workers comp injury or third party accident? ☐Yes ☐No

Do you have any history of the following:

Heart disease	☐Yes	☐No	High blood pressure	☐Yes	☐No
Kidney disease	☐Yes	☐No	Cancer	☐Yes	☐No
Liver disease	☐Yes	☐No	Diabetes	☐Yes	☐No
Bleeding disorders	☐Yes	☐No	Chronic breathing problems	☐Yes	☐No

Other: _____

If yes to any of the above, please explain: _____

_____

Are you currently taking any medications? (including: over-the-counter medications, vitamin supplements or health-food supplements) ☐Yes ☐No

Please list: _____

_____

Are you allergic to any medications? ☐Yes ☐No

Please list: _____

Do you have any allergies? ☐Yes ☐No

Please list: _____

Have you undergone surgery in the past? ☐Yes ☐No

Please list the type of surgery including date(s): _____

_____

Have you ever had problems with anesthesia? ☐Yes ☐No

If so, please explain: _____

Are you currently or previously been treated by a Mental Health Care Professional? ☐Yes ☐No

If answered yes to the above, please list any medications prescribed _____

_____

If you have any other medical problems or conditions not listed above, please list: _____

_____

Do you smoke cigarettes? ☐Yes ☐No If yes, how many packs per day/week? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much per day/week? _____

I HAVE READ AND ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY KNOWLEDGE.

If you are completing this form for another person, please list your name and relationship to the patient:

Name: _____ Relationship: _____

If the patient is a minor, parent or guardian signature please.

Patient Signature: _____ **Date**: _____

Print Patient Name: _____ **DOB**: _____