JOSEPH F. MAZZA, JR, MD

12640 Creekside Lane ~ Fort Myers, Florida ~ 33919
Phone (239) 482-7676 ~ Fax (239) 482-7604

Patient Health History

NAME: **Date:** **Date of Birth:**

HEIGHT: _____ **WEIGHT:** _____

MEDICATIONS: List all current medications including non-prescription drugs, herbs, and supplements. If you have a separate list of medications please provide the front desk with the list and print "see list" below in the first box.

Name	Strength	Frequency	Name	Strength	Frequency
1.			5.		
2.			6.		
3.			7.		
4.			8.		

ALLERGIES: (Please List Allergy and Reaction) _____

☐ **NO ALLERGIES**

PATIENT CURRENT / PAST MEDICAL HISTORY:

	YES	NO		YES	NO		YES	NO		YES	NO
Alcohol/Drug Problems	☐	☐	Fever/Blisters Cold Sores	☐	☐	High Blood Pressure	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	High Cholesterol	☐	☐	Stomach/Intestinal Problems	☐	☐
Arthritis	☐	☐	Gout	☐	☐	Kidney Disease	☐	☐	Stroke	☐	☐
Asthma/Emphysema	☐	☐	Heart Disease	☐	☐	Mental Problems	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Hereditary Diseases	☐	☐	Migraine	☐	☐	Tuberculosis	☐	☐

Have you ever experienced bleeding tendencies? ☐ Yes ☐ No

Are you currently under psychiatric care? ☐ Yes ☐ No

Do you have a psychiatric diagnosis? ☐ Yes ☐ No If Yes, please explain _____

Have you ever or are you currently taking medications for a psychiatric diagnosis? _____

Are you currently taking a diuretic medication ☐ Yes ☐ No If yes please list name: _____

Have you ever experienced or been diagnosed with sleep apnea? ☐ Yes ☐ No

ADDITIONAL MEDICAL PROBLEMS / PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS INJURIES:

1.	Date:		4.	Date:	
2.	Date:		5.	Date:	
3.	Date:		6.	Date:	

SOCIAL HISTORY:

Do you currently smoke/vape:
☐ No ☐ Yes (if yes, packs/day) _____ Years _____ Packs/Day

Did you smoke in the past?
☐ No ☐ Yes (when stopped) _____

Do you use recreational drugs? (**This includes medica marijuana/vaporized marijuana)**
☐ No ☐ Yes (Please list types): _____

Do you drink alcohol:
☐ No ☐ Yes (if yes, amount/week) _____

Do you drink caffeine:
☐ No ☐ Yes (if yes, list amount) _____

FAMILY MEDICAL HISTORY (Immediate family only):

Family Member: _____ Dx: _____ Family Member: _____ Dx: _____

Family Member: _____ Dx: _____ Family Member: _____ Dx: _____

Family Member: _____ Dx: _____ Family Member: _____ Dx _____

Primary Care Physician
Name: _____ Phone Number: _____
Cardiologist
Name: _____ Phone Number: _____

Malignant Hyperthermia Risk Screening

Please check of the following that apply to you:

1. Do you have a family history of unexpected death(s) following general anesthesia or exercise?
☐ **Yes** ☐ **No**

2. Do you have a family OR personal history of Malignant Hyperthermia, a muscle or neuromuscular disorder, high temperature following exercise?
☐ **Yes** ☐ **No**

3. Do you have a personal history of muscle spasm, dark or chocolate-colored urine?
☐ **Yes** ☐ **No**

4. Do you have personal history of unanticipated fever immediately following anesthesia or serious exercise?
☐ **Yes** ☐ **No**

Signature: _____ ***Date:*** _____