

MEDICAL HISTORY

PATIENT NAME: _____ DOB: _____ TODAY'S DATE: _____

REASON FOR TODAY'S VISIT: _____

PREVIOUS TREATMENT FOR THIS PROBLEM: _____

HAVE YOU EVER HAD THE FOLLOWING? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart attack / arterial disease | <input type="checkbox"/> Heartburn/reflux/hiatal hernia | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Other heart issue: _____ | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Problems with anesthesia | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Cholesterol issues |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Lung problems/COPD |
| <input type="checkbox"/> Cancer(s), type(s) and date of diagnosis: _____ | | |
| <input type="checkbox"/> NONE OF THE ABOVE | | |

LIST ALL OTHER PAST & CURRENT MEDICAL ISSUES

_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ALL SURGERIES AND DATES

_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ALL CURRENT MEDICATIONS AND DOSES (include supplements and any over-the-counter medications)

_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU TAKE ASPIRIN? NO YES DOSE: _____ mg/day

LIST ALL DRUG ALLERGIES AND REACTIONS NO KNOWN DRUG ALLERGIES

_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

TOBACCO USE NEVER YES / CIGARETTES # _____ packs per day for _____ years / SMOKELESS TOBACCO # _____ years

QUIT _____ years/months ago. | PREVIOUSLY SMOKED # _____ packs per day for _____ years

ALCOHOL USE NEVER DRINKS # _____ per week | NO ALCOHOL for _____ months/years

CAFFEINE USE NONE YES HOW MUCH? # _____ caffeinated drinks most days

FAMILY MEDICAL HISTORY

Any family history with life-threatening reaction to anesthesia? _____

MOTHER: Alive | Died age: _____ Significant Medical Problems: _____

FATHER: Alive | Died age: _____ Significant Medical Problems: _____

SIBLINGS: _____ #sisters / _____ #brothers Significant Medical Problems: _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Decreased energy level |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Excessive urination |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> Limb weakness | |
| <input type="checkbox"/> NONE OF THE ABOVE | |