MEDICAL HISTORY

Name: _____ Date: _____

Last *First* *M.I.*

SOCIAL

Sex: M ☐ F ☐ Married: Y ☐ N ☐ Weight: _____ Height: _____

Tobacco / Smoking: Y ☐ N ☐ Type / Amount: _____ Alcohol: Y ☐ N ☐ Type / Amount: _____

MEDICATIONS: (Name & dose)

Aspirin Use (Bayer, Excedrin, Anacin, etc.): _____ Antidepressants / Tranquilizers: _____

NSAID's (Advil, Motrin, Ibuprofen): _____ Blood Pressure Meds: _____

Fluid Pills: _____ Heart Pills: _____

Anticoagulants (Blood thinners): _____ Diabetic Meds: _____

Sedatives or sleeping pills: _____ Diet Pills: _____

Cortisone Pills or Injections: _____ Pain Pills: _____

Laxatives: _____

Non-Prescription Drugs: (Vitamins, Diet Pills, Herbs, Laxatives, etc.) _____

_____

Drug Allergy: Y ☐ N ☐ List specific drug(s) and type of reaction (e.g. rash, nausea, breathing difficulty): _____

_____

Latex Allergy: Y ☐ N ☐ Tape Allergy: Y ☐ N ☐

FAMILY HISTORY: Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y ☐ N ☐ Kidney Disease: Y ☐ N ☐ Heart Disease: Y ☐ N ☐ Cancer: Y ☐ N ☐

Abnormal Clotting: Y ☐ N ☐ Diabetes: Y ☐ N ☐ Anesthesia Problems: Y ☐ N ☐

Please describe questions with a "Yes" answer: _____

_____

PERSONAL PAST HISTORY: Have you ever had or do you still have:

Abnormal Bleeding:	Y ☐	N ☐	Neck or back injury:	Y ☐	N ☐	Kidney Disease:	Y ☐	N ☐	Heart Murmur:	Y ☐	N ☐
Abnormal Clotting:	Y ☐	N ☐	Chest Pain/Angina:	Y ☐	N ☐	Epilepsy:	Y ☐	N ☐	Hypertension:	Y ☐	N ☐
Acid Reflux:	Y ☐	N ☐	Irregular Heart Beat:	Y ☐	N ☐	Anemia:	Y ☐	N ☐	Weight Change >20 lbs.:	Y ☐	N ☐
Diabetes:	Y ☐	N ☐	Sleep Apnea:	Y ☐	N ☐	Asthma:	Y ☐	N ☐	Thyroid Trouble:	Y ☐	N ☐
Bronchitis/chronic cough	Y ☐	N ☐	Heart Attack:	Y ☐	N ☐	Stroke:	Y ☐	N ☐	Staph Infection:	Y ☐	N ☐
Liver trouble/Hepatitis:	Y ☐	N ☐	Shortness of breath:	Y ☐	N ☐	Emphysema:	Y ☐	N ☐	Cancer:	Y ☐	N ☐
Other illness not mentioned:	Y ☐	N ☐									

Please describe questions with a "Yes" answer: _____

_____

Have you ever received a transfusion? Y ☐ N ☐ If yes, what year? _____

Do you wear: Contact lenses: Y ☐ N ☐ Eye glasses: Y ☐ N ☐ Hearing aid: Y ☐ N ☐ Dentures: Y ☐ N ☐

Previous Surgery, year and type of procedure: _____

_____

Indicate the type(s) of anesthesia received in the past and list any complications/reactions you experienced:

Local anesthesia - complications/reactions: _____

General anesthesia - complications/reactions: _____

Spinal/Epidural - complications/reactions: _____

Date last seen by Primary Care Physician: _____

Primary Care Physician (name) _____ (telephone) (_____) _____

WOMEN PATIENTS ONLY:

Number of pregnancies _____ Number of children _____ Did you breast feed? Y ☐ N ☐

Last Menstrual Period: _____ Is there a possibility that you are pregnant? Y ☐ N ☐

_____ _____

Signature Date