

MEDICAL HISTORY

Name: _____ Date: _____ Male Female

Ht _____ Wt _____ Age _____ Referring/Primary Care Physician: _____

MEDICATION HISTORY None

Current Medications and Dosage: _____

ALLERGIES None

Medications: _____

Type of Reaction: _____

Latex: No Yes Other Allergies: _____

Type of Reaction: _____

PATIENT'S SURGERIES & MEDICAL HISTORY (Check all that apply)

Surgeries	No	Yes	Date	Medical History	No	Yes	Date
Breast	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease / High Blood Pressure / Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disease (TB, Asthma, Pneumonia, CF)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back/Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Jaundice / Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nasal/Sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach Problems / Ulcers / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastric Bypass	<input type="checkbox"/>	<input type="checkbox"/>	_____	Speech/Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other Surgeries, Hospitalizations, or Serious Diseases: _____

REVIEW OF SYSTEMS (Check all that apply)

CARDIORESPIRATORY

- Chest pain (angina)
- Palpitations
- Shortness of breath
- Wheezing
- Fainting spells
- Foot and ankle swelling

GASTROINTESTINAL

- Appetite
- Nausea/Vomiting
- Spitting of blood
- Rectal bleeding
- Change in bowel habits
- Pain

GENITOURINARY

- Painful urination
- Blood in urine
- Menstrual problems
- Menopause
- Infection
- Stones

NERVOUS SYSTEM

- Convulsions
- Paralysis

BONE & JOINT

- Arthritis
- Bone problems

Continued on Reverse ➔

FAMILY HISTORY

None

Heart Disease Diabetes Cancer Asthma

Bleeding Disorder High Blood Pressure TB Kidney Disease

Mother Living No Yes Age Deceased _____ Cause of Death _____

Father Living No Yes Age Deceased _____ Cause of Death _____

PATIENT SOCIAL HISTORY

Smoking: _____ packs per day Year Quit: _____ Alcohol: _____ oz per day

Do you, or have you ever used any recreational street drugs: No Yes

Please list: _____

Have you or a family member ever had a problem with:

Anesthesia No Yes Malignant Hyperthermia No Yes

Specify: _____

Have you ever had:

Blood Transfusion No Yes Prolonged Bleeding No Yes

If so, explain: _____

Should you require surgery, are you willing to receive a blood transfusion, if necessary?

No Yes Please initial here: _____

CHECK ANY RECENTLY TAKEN: ❖ DISCONTINUE TWO WEEKS PRIOR TO SURGERY ❖

ASPIRIN ANTI-INFLAMMATORIES VITAMIN E DIETARY SUPPLEMENTS
(such as Ibuprofen, Advil, Motrin)

HERBAL MEDICATIONS

echinacea ephedra (Ma-Huang) feverfew garlic ginger ginkgo

ginseng goldenseal kava-kava licorice St. John's Wort Valerian

Patient/Guardian Signature

Office Nurse