



**PATIENT MEDICAL HISTORY FORM**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

MALE  FEMALE HT: \_\_\_\_\_ WT: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

**CURRENT MEDICATIONS** - Please list all current prescriptions, over-the-counter medications, including vitamins and herbal supplements:  None

Medication Name	Dosage/Frequency	Last Dose	Medication Name	Dosage/Frequency	Last Dose

**ALLERGIES**  No Allergies  Penicillin  Sulfa  Aspirin  Iodine  Latex  Soy  Eggs  
 Other: \_\_\_\_\_ If you have allergies, describe reaction(s): \_\_\_\_\_

**MEDICAL HISTORY** - Please check all that apply:

- |  |   |  |   |   |
|--|---|--|---|---|
| <input type="checkbox"/> Acid reflux       | <input type="checkbox"/> Chest pain/angina    | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> HIV or AIDS              | <input type="checkbox"/> Phlebitis          |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Chronic anxiety      | <input type="checkbox"/> Diverticulitis      | <input type="checkbox"/> Irregular heart beat     | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Chronic cough        | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Radiation therapy  |
| _____                                      | <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Kidney disease/failure   | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Chronic sinusitis    | <input type="checkbox"/> Gout                | <input type="checkbox"/> Kidney infection         | <input type="checkbox"/> Sleep apnea        |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Cirrhosis of liver   | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Kidney stones            | <input type="checkbox"/> Stroke/paralysis   |
| <input type="checkbox"/> Blood clots       | <input type="checkbox"/> Thyroid disease      | <input type="checkbox"/> Heart failure       | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> TB (Tuberculosis)  |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Colon cancer         | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Lupus                    | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Colon polyps         | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Multiple sclerosis       | <input type="checkbox"/> Other: _____       |
| _____                                      | <input type="checkbox"/> Crohn's Disease      | <input type="checkbox"/> Hiatal/Groin hernia | <input type="checkbox"/> Pancreatitis             |   |
|  |   | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Parkinson's disease      |   |

**CURRENT MEDICAL CONDITIONS**

Do you use oxygen?  No  Yes Are you taking any MAOIs?  No  Yes  
 Have you taken Prednisone or other steroids for your breathing in the last 3 months?  No  Yes  
 Have you had pneumonia or bronchitis in the past 6 months?  No  Yes

**HEALTH HABITS**

Smoking history  Never  Yes; \_\_\_\_\_ packs/day for \_\_\_\_\_ years Currently smoking?  No  Yes  
 Other tobacco use  No  Yes; details: \_\_\_\_\_  
 Alcohol  No  Yes; amount per day: \_\_\_\_\_  
 Drug use  No  Yes; specify drugs and amounts: \_\_\_\_\_

**SURGICAL HISTORY**  No Prior Surgeries

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Angioplasty     | <input type="checkbox"/> D&C                  | <input type="checkbox"/> Hysterectomy  | <input type="checkbox"/> Spine (back/neck)   |
| <input type="checkbox"/> Appendectomy    | <input type="checkbox"/> Gallbladder          | <input type="checkbox"/> Implanted Defibrillator   | <input type="checkbox"/> Splenectomy   |
| <input type="checkbox"/> Arthroscopy     | <input type="checkbox"/> Heart Cath           | <input type="checkbox"/> Kidney Removal  | <input type="checkbox"/> Tonsils/Adenoids  |
| <input type="checkbox"/> Breast Biopsy   | <input type="checkbox"/> Heart Valve Replaced | <input type="checkbox"/> Mastectomy, <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Total Hip, <input type="checkbox"/> L <input type="checkbox"/> R  |
| <input type="checkbox"/> Cardiac Bypass  | <input type="checkbox"/> Hemorrhoidectomy     | <input type="checkbox"/> Pacemaker   | <input type="checkbox"/> Total Knee, <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Cataract        | <input type="checkbox"/> Hernia               | <input type="checkbox"/> Prostate  |  |
| <input type="checkbox"/> Other(s): _____ |   |  |  |

**ANESTHESIA HISTORY**

Have you ever had anesthesia?  No  Yes Have you ever had a problem with anesthesia?  No  Yes  
 Has any member of your family had a problem with anesthesia?  No  Yes  
 Do you have: Loose/chipped/capped teeth?  No  Yes Bridges/dentures?  No  Yes  
 Trouble opening mouth or jaw clicking?  No  Yes

Reviewing Nurse Signature: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_ Time: \_\_\_\_\_