

PATIENT HISTORY

PLEASE PRINT

TODAY'S DATE: ___/___/___

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NAME: _____ DOB: ___/___/___ AGE: _____
Last First MI

Height: ___ ft. ___ in. Weight: ___ lbs. BMI

Dominate hand: right left

If female, are you or could you be PREGNANT? yes no

SOCIAL HISTORY

Alcohol use: none/rare daily weekly monthly

Tobacco use: no cigarettes cigars chew/dip How much per day? _____ quit--when? _____

Recreational drug use: no yes What? _____

Living arrangements: alone family friend other _____

PAST MEDICAL HISTORY

Check all conditions that you **currently have** or have had in the past:

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> aids or HIV | <input type="checkbox"/> blood transfusions | <input type="checkbox"/> gout | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> polio |
| <input type="checkbox"/> anemia | <input type="checkbox"/> cancer | <input type="checkbox"/> heart attack | <input type="checkbox"/> lupus | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> angina | <input type="checkbox"/> chest pain | <input type="checkbox"/> heart disease | <input type="checkbox"/> migraines | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> congestive heart dz. | <input type="checkbox"/> heart murmur | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> asthma | <input type="checkbox"/> diabetes | <input type="checkbox"/> hepatitis | <input type="checkbox"/> obesity | <input type="checkbox"/> stroke |
| <input type="checkbox"/> back trouble | <input type="checkbox"/> emphysema | <input type="checkbox"/> kidney disease | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> stomach ulcer |
| <input type="checkbox"/> bladder infections | <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> kidney stones | <input type="checkbox"/> pneumonia | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> bleeding disorders | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> post menopausal | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> glaucoma | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> other (list) _____ | |

List **ALL CURRENT MEDICATIONS AND DOSAGES** (this includes pain meds/over-the-counter meds/supplements or vitamins/as needed medications/and any medication you have taken in the past two weeks):

_____	_____	_____
_____	_____	_____
_____	_____	_____

List **MEDICATION ALLERGIES** and reactions: none latex

_____	_____	_____
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PAST SURGICAL HISTORY

List all your surgeries and year:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had any problems with anesthesia? no yes If yes, explain: _____

