Medical History

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Referred By: _____ Primary Care Provider: _____

Additional Treating Physicians: _____

_____

Gender: ☐ M ☐ F Chief Complaint: _____

Are you currently taking any medications? ☐ No ☐ Yes, Please list strength and dosage: _____

_____

_____

_____

Latex Allergy? ☐ No ☐ Yes Medication Allergies? ☐ No ☐ Yes, Please list medication and reaction: _____

_____

Other Allergies? ☐ No ☐ Yes, Please list, include reaction: _____

_____

Medical History (Please Check All That Apply)

Heart Disease/High Blood Pressure/Stroke: ☐ No ☐ Yes

Lung - TB, Asthma, Pneumonia, CF: ☐ No ☐ Yes

Diabetes: ☐ No ☐ Yes

Jaundice/Hepatitis: ☐ No ☐ Yes

Seizures/Epilepsy: ☐ No ☐ Yes

Stomach Problems/Ulcers/Reflux: ☐ No ☐ Yes

Cancer: ☐ No ☐ Yes

Sleep Apnea: ☐ No ☐ Yes

Speech/Hearing Problems: ☐ No ☐ Yes

Down Syndrome: ☐ No ☐ Yes

Surgical History (Please Check All That Apply, List Date/Details)

Breast: ☐ No ☐ Yes: _____

Hysterectomy: ☐ No ☐ Yes: _____

Back/Neck: ☐ No ☐ Yes: _____

Throat: ☐ No ☐ Yes: _____

Ear: ☐ No ☐ Yes: _____

Nasal/Sinus: ☐ No ☐ Yes: _____

Heart: ☐ No ☐ Yes: _____

Eye: ☐ No ☐ Yes: _____

Bariatric Surgery: ☐ No ☐ Yes: _____

Other Surgeries, Hospitalizations or Serious Diseases: _____

_____

_____

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

Anesthesia: ☐ No ☐ Yes Malignant Hypothermia: ☐ No ☐ Yes

Please explain: _____

Have you ever had: Blood Transfusion(s): ☐ No ☐ Yes Prolonged Bleeding: ☐ No ☐ Yes

Please explain: _____

Social History

Smoking: ☐ No ☐ Yes ☐ Formerly; Packs Per Day: _____ Year Quit: _____

Alcohol: ☐ No ☐ Yes ☐ Formerly; Number of Drinks/Week: _____ Year Stopped: _____

Review of Systems (Please Check All That Apply)

CARDIORESPIRATORY	GASTROINTESTINAL	GENITOURINARY	NERVOUS SYSTEM
☐ Chest Pain (Angina)	☐ Appetite	☐ Painful Urination	☐ Convulsions
☐ Palpitations	☐ Nausea/Vomiting	☐ Blood in Urine	☐ Paralysis
☐ Shortness of Breath	☐ Spitting Blood	☐ Menstrual Problems	BONE & JOINT
☐ Wheezing	☐ Rectal Bleeding	☐ Menopause	☐ Arthritis
☐ Fainting Spells	☐ Change in Bowel	☐ Infection	☐ Bone Problems
☐ Foot/Ankle Swelling	Habits	☐ Stones	
	☐ Pain		

Family History (Please Check All That Apply)

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Asthma ☐ Bleeding Disorder ☐ High Blood Pressure

☐ Tuberculosis ☐ Kidney Disease ☐ Other: _____

Mother Living: ☐ Yes ☐ No; Age Deceased: _____ Cause of Death: _____

Father Living: ☐ Yes ☐ No; Age Deceased: _____ Cause of Death: _____

_____ _____

Signature of Patient or Authorized Party Date

_____ _____

Printed Name of Patient or Authorized Party Relationship to Patient