

MEDICAL HISTORY

Updated 5/20/09

NAME _____ DATE _____ CHART# _____

ALLERGIES? MEDICATIONS/FOODS _____

METAL? _____ LATEX? _____

WHAT BODY PART ARE YOU SEEING US FOR? _____

WAS THIS JOB RELATED? Y/N

HAVE X-RAYS BEEN MADE? Y/N WHERE AND WHEN _____

HAS MRI BEEN MADE? Y/N WHERE AND WHEN _____

WHEN WAS YOUR LAST TETANUS SHOT? _____

LIST ALL SURGICAL PROCEDURES YOU HAVE HAD IN THE PAST:

PROCEDURE	YEAR/SURGEON/LOCATION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ANY ANESTHESIA PROBLEMS IN PAST SELF/BLOOD RELATIVES? YES/NO
IF YES WHAT SYMPTOMS/PROBLEMS OCCURRED? _____

FAMILY *MEDICAL HISTORY*: **CIRCLE** CORRECT RESPONSE

MOTHER --living/deceased__diabetic/high blood pressure/heart disease/other_____

FATHER--- living/deceased__diabetic/high blood pressure/heart disease/other_____

IS THERE ANY CHANCE THAT YOU ARE PREGNANT? Y/N

DO YOU SMOKE? Y/N HOW MANY CIGARETTES/CIGARS PER DAY? _____

HOW LONG HAVE YOU SMOKED? _____

DO YOU DRINK ALCOHOL? Y/N WHAT TYPE? _____

HOW MANY PER WEEK? _____

DO YOU USE RECREATIONAL DRUGS (COCAINE, MARIJUANA, ETC.)? Y/N

IF SO, WHAT? _____ HOW MUCH PER WEEK? _____

CURRENT MEDICATIONS: INCLUDE DOSAGES PLEASE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CLINIC INITIALS _____ DATE: _____ MD INITIALS _____

MEDICAL HISTORY 2ND PAGE

Updated 5/20/09

DATE _____ NAME _____ CHART# _____

HEIGHT _____ WEIGHT _____ AGE _____ (If BMI > 35 see anesthesia
To approve for SASC)

TEMP _____

Are you currently having or have you had problems with: (PLEASE CIRCLE)

EYES YES NO _____

EARS, NOSE, THROAT YES NO _____

LUNGS/BREATHING YES NO _____ (ANESTH, CXR)

IF YES, (PLEASE CIRCLE) ASTHMA, COPD, EMPHYSEMA, PNEUMONIA, BLACK LUNG,
TUBERCULOSIS, SHORTNESS OF BREATH, BRONCHITIS, SLEEP APNEA

HEART YES NO _____ (EKG) OVER 50=EKG

IF YES, PLEASE CIRCLE MITRAL VALVE PROLAPSE, RHEUMATIC FEVER,
CHEST PAIN/PRESSURE, HEART MURMUR, PACEMAKER, IRREG. HEART RATE
HIGH CHOLESTEROL, HIGH BLOOD PRESSURE, HEART ATTACK, ANGINA

GASTROINTESTINAL/DIGESTION YES NO _____

IF YES, PLEASE CIRCLE
ACID REFLUX, STOMACH ULCERS, HEPATITIS (A, B, C),
BOWEL MOVEMENT, HIATAL HERNIA

BLADDER/DIFFICULTY URINATING YES NO _____

KIDNEY/RENAL FAILURE/DIALYSIS YES NO _____ ((CMP)

BROKEN BONE/MUSCLE WEAKNESS YES NO _____

MULTIPLE SCLEROSIS/POLIO YES NO _____

PSORIASIS/RASH/SKIN INFECTION YES NO _____

STROKE, NUMBNESS, CONVULSIONS TINGLING, FAINTING, SEIZURES
YES NO _____

PSYCHIATRIC,ALZHEIMERS,DEPRESSION YES NO _____

DIABETES YES NO _____ ((BMP, EKG)

IF YES, DO YOU TAKE INSULIN YES NO

THYROID PROBLEMS YES NO _____

BLEEDING PROBLEMS/ANEMIA
LEUKEMIA, SICKLE CELL,
FREE BLEEDER, LYMPHOMA YES NO _____ (CBC)

ARE YOU ON A BLOOD THINNER? YES NO _____ (PT/PTT)

DO YOU TAKE ASPIRIN DAILY? YES NO _____

HIV/AIDS, INFECTIOUS DISEASE YES NO _____

CANCER YES NO _____

ARTHRITIS/RHEUMATOLOGIC
PROBLEMS, GOUT YES NO _____

ARE YOU PREGNANT OR IS THERE ANY POSSIBILITY YOU MIGHT BE PREGNANT? _____
DATE OF LAST MENSTRUAL PERIOD _____

HAVE YOU EXPERIENCED ANY RECENT SIGNIFICANT WEIGHT LOSS OR GAIN? _____

DO YOU HAVE ANY OTHER PROBLEMS NOT MENTIONED ABOVE? _____

CLINIC INITIALS _____ MD INITIALS _____ DATE: _____