MEDICAL / SURGICAL HISTORY

Patient Name: Today's Date:
Patient No: Surgery Date:
Surge on Name:

Knowledge of your general health and medical background is essential to us. Please complete the following information. <u>Please do not leave any blanks</u>; write "none" if that is appropriate. Ask if you have questions.

Age: Height: Weight: Occupation:
Please list ALL medications you are currently taking or have used in the past 6 months, including birth control pills or hormone replacement therapy; aspirin-or ibuprofen-containing drugs; any weight control medications; steroids; blood thinners (like Coumadin), drugs to treat epilepsy, glaucoma, diabetes, asthma, heart problems, or high blood pressure (including diuretics); pain medications; sleeping pills, tranquilizers or anti-depressants.
Medication(s): Amount Frequency
List all drug allergies and reactions:
Have you ever used illegal drugs? YES/NO
Are you a smoker? YES/NO Ex-Smoker? YES/NO Non-Smoker? YES/NO
How much are (were) you smoking? How long? Quit how long ago?
How much alcohol do you drink? Caffeine?
Please circle all of the following medial conditions you now have or have had in the past: bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / Heart attack / hypertension / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / any other serious illness or injury / None of the above
Is there any possibility that you may be pregnant at this time? YES/NO
List all surgeries that you have had (including plastic surgery): Date:
Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers? YES/NO
Have you or anyone in your family ever had blood clots in the legs or longs? YES/NO Swelling, pain, discoloration or ulcers in our legs? YES/NO
Do you have (circle): loose or chipped teeth/caps/dentures/contact lenses/None
Have you ever seen a cardiologist? YES/NO Physician Name:
Date of last EKG:

Patient Signature:
Date: