MEDICAL HISTORY

PATIENT NAME: _____ TODAY'S DATE: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (please check)

YES	NO		YES	NO		YES	NO	
___	___	High Blood Pressure	___	___	Leukemia/Lymphoma	___	___	Frequently Tired
___	___	Heart Attack	___	___	Cancer	___	___	Difficulty Sleeping
___	___	Heart Disease	___	___	Tuberculosis	___	___	Use of CPAP for Apnea
___	___	Cardiac Pacemaker	___	___	Hepatitis/Yellow Jaundice	___	___	Snore/Stop Breathing
___	___	Heart Murmur	___	___	AIDS/HIV	___	___	Headaches/Migraines
___	___	Mitral Valve Prolapse	___	___	MRSA(Staph. wound inf)	___	___	Dry Eyes
___	___	Stroke	___	___	Liver Disease	___	___	Glaucoma
___	___	Abnormal EKG	___	___	Kidney Disease	___	___	Double Vision
___	___	Artificial joints/Heart Valves	___	___	Thyroid Problems	___	___	Fainting
___	___	Blood Clots in Legs/Lungs	___	___	Diabetes	___	___	Heart Burn/Indigestion/Ulcers
___	___	Abnormal Chest x-rays	___	___	Keloids	___	___	Herpes/Cold Sores
___	___	Uncontrolled Bleeding	___	___	Epilepsy/Seizures	___	___	Depression/Anxiety
___	___	Asthma/COPD	___	___	Fractures: face, neck or jaw	___	___	Frequent Urination/Blood
___	___	Shortness of Breath	___	___	Recent wt loss/gain—15 lbs	___	___	Other_____
___	___	Emphysema	___	___	Radiation/Chemotherapy Year: _____	___	___	Pregnant/LMP_____

SOCIAL HISTORY: (please check)

Smoking: ___ None ___ Quit ___ Cigarettes ___ Cigars/pipe
How much: _____ If Quit-what year: _____

Alcohol: ___ None ___ Quit ___ Beer ___ Wine ___ Other
How much: _____ If Quit-what year: _____

Do you use Recreational Drugs: ____ Yes ____ No
If Quit-what year: _____

FAMILY HISTORY: (please circle)

Heart Trouble Stroke Diabetes Cancer

Bleeding Disorder Reaction to Anesthesia

_____ _____ _____ _____
Patient (or Guardian) Signature Date Reviewed by Date

8/08