MEDICAL HISTORY

PATIENT NAME:_____ DATE OF BIRTH:_____

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	___	___	Heartburn/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 or gain-15 lbs	___	___	Other _____		
Emphysema	___	___	Radiation/Chemotherapy	___	___	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