**MEDICAL HISTORY FORM** Date:_____

**First Name:**

**Last Name:**

**Date of Birth:**

***Circle*: Female or Male**

**Height:**

**Weight:**

**Medications/Supplements:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Are you currently under the care of a physician? Yes No**

**Doctor Name:**_____

**Date of Last Physical Exam:** _____

**Any Health Changes in the past Year?**
**Yes No**

*Your answers are confidential and are for healthcare purposes only*

**Alcohol Use:** Yes No
**(Drinks Per Day):**_____

**Tobacco Use:** Yes No
**(Packs Per Day):**_____

**Recreational Drug Use:** Yes No

_____

**Hospitalizations/Surgeries:**

_____

_____

_____

_____

_____

**Anesthesia History:**

Any Problems with Previous Anesthesia "Being Put To Sleep"?
Yes No

Any issues with nausea or vomiting after anesthesia?
Yes No

Any family history of problems with anesthesia?
Yes No

**Allergies : Please Circle**

- Aspirin
- Acetaminophen (Tylenol)
- Beef
- Benzodiazepines (Valium, Versed, Xanax)
- Clonidine
- Iodine
- Latex
- Local Anesthetics (Novocaine, Lidocaine, etc)
- Narcotic Pain Medications Codeine, Demerol, Dilaudid, Fentanyl, Hydrocodone, Oxycodone, etc)
- Pork
- Seasonal Allergies
- Sulfa
- Penicillin
- Other:
- No Allergies

**Past Medical History**
***Have you had or do you currently have any of the following? (please "X" Yes or No to each item)***

| Yes | No | | Comments: | Yes | No | | Comments |
|---|---|---|---|---|---|---|---|
| | | **General Health** | | | | **Nerve Health** | |
| | | Fever/Chills | | | | Seizures | |
| | | Unintended Weight Loss | | | | Stroke | |
| | | **Heart Health** | | | | TIA (Mini Stroke) | |
| | | High Blood Pressure | | | | Paralysis | |
| | | Low Blood Pressure | | | | Epilepsy | |
| | | Heart Attack | | | | Dementia | |
| | | Angina (Chest Pains) | | | | Headaches | |
| | | Arrythmias/Palpitations | | | | Memory Loss | |
| | | Murmurs | | | | Numbness | |
| | | Heart Failure | | | | Weakness | |
| | | Congenital Heart Disease | | | | Neuropathy | |
| | | Shortness of Breath with Activity | | | | Fibromyalgia | |
| | | Mitral Valve Prolapse | | | | Other Nerve Problem | |
| | | Heart Stents | | | | **Bone Health** | |
| | | Heart Bypass | | | | Osteoarthritis | |
| | | Pacemaker | | | | C-Spine (Neck) Problems | |
| | | Arteriosclerosis | | | | Osteoporosis | |
| | | Scarlet Fever/Rheumatic Fever | | | | Joint Replacement | |
| | | Other Heart Condition | | | | Other Bone Problem | |
| | | **Lung Health** | | | | **Digestive Health** | |
| | | Asthma | | | | Acid Reflux (GERD) | |
| | | COPD | | | | Crohn's | |
| | | Emphysema | | | | Colitis | |
| | | Bronchitis | | | | Stomach Ulcers | |
| | | Pneumonia | | | | Hiatal Hernia | |
| | | Obstructive Sleep Apnea | | | | Gastric Bypass | |
| | | History of Sinus Infections | | | | Anorexia | |
| | | Other Lung/Breathing Problem | | | | Bulimia | |
| | | **Liver Health** | | | | Other Digestive Problem | |
| | | Hepatitis | | | | **Mental Health** | |
| | | Cirrhosis | | | | Anxiety | |
| | | Other Liver Condition | | | | Depression | |
| | | **Kidney Health** | | | | Psychiatric Hospitalization | |
| | | Kidney Failure | | | | Alcohol/Drug Addiction | |
| | | Dialysis | | | | Other Mental Health Issue | |
| | | Kidney Transplant | | | | **Immune Health** | |
| | | Kidney Stones | | | | Lupus | |
| | | Other Kidney Condition | | | | Chemotherapy | |
| | | **Bleeding Disorders** | | | | Sjogrens Syndrome | |
| | | Bruise Easily | | | | Rheumatoid Arthritis | |
| | | Anemia | | | | AIDS/HIV | |
| | | Sickle Cell Disease/Trait | | | | Multiple Sclerosis | |
| | | Hemophilia or Von Willibrands | | | | Other Immune Issue | |
| | | **Endocrine Health** | | | | **Developmental Challenge** | |
| | | Diabetes | | | | Cerebral Palsy | |
| | | High Thyroid (Hyperthyroid) | | | | Autism Spectrum | |
| | | Low Thyroid (Hypothyroid) | | | | Down's Syndrome | |
| | | Steroid Use (ex: Prednisone) | | | | Fetal Alcohol Syndrome | |
| | | | | | | Other Developmental Issue | |
| | | | | | | | |
| | | **PREGNANT?** | | | | | |
| | | **NURSING?** | | | | **CANCER? What Type?** | |

**Patient Signature:**_____ **Date:** _____

Updated by Doctor
Date:
Date:
Date: