Patient Medical History

Patient ID# _____ Name _____ Date _____

Date of Birth _____ Age _____ ☐ Male ☐ Female Height _____ Weight _____

Primary Language _____ Specialty Physician _____

Primary Care Physician _____ Date of Last Visit _____

Please list all allergies (medication, food, environmental)

_____

_____

Please list all medications you are currently taking (prescription, over-the-counter, herbal)

Medication	Reason for Medication	Medication	Reason for Medication

Please list all previous surgeries and recent hospitalizations

_____

_____

_____

Please check (✓) correct response

Have you ever smoked? If yes, for how long? _____ Year quit? _____ Packs per day? _____	☐ Yes ☐ No	Have you taken oral steroids within the last 6 months? If so, which? _____	☐ Yes ☐ No
Do you drink alcohol? If yes, how much/often? _____	☐ Yes ☐ No	Do you have caps, bridges, dentures, or loose teeth?	☐ Yes ☐ No
Do you use recreational drugs? If yes, which? _____	☐ Yes ☐ No	Do you exercise? Type/frequency? _____	☐ Yes ☐ No
Do you take blood thinners such as aspirin or ibuprofen? If yes, which? _____	☐ Yes ☐ No	Have you or your immediate family had unusual reactions, problems, or complications associated with anesthesia? If yes, describe _____ _____	☐ Yes ☐ No
Have you used diet pills in the last 2 weeks? If yes, which?_____	☐ Yes ☐ No		

Please check all that apply

Neurological		**Gastrointestinal**	
Stroke/TIA	☐ Yes ☐ No	Heartburn	☐ Yes ☐ No
Paralysis	☐ Yes ☐ No	Acid reflux	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Peptic ulcers/GI bleed	☐ Yes ☐ No
Memory loss	☐ Yes ☐ No	Hepatitis/Liver disease/Jaundice	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Motion sickness	☐ Yes ☐ No
Head injury	☐ Yes ☐ No	**Endocrine**	
Fainting	☐ Yes ☐ No	Diabetes (if yes, indicate how controlled) ☐ Diet ☐ Oral Meds ☐ Insulin	☐ Yes ☐ No
Depression/anxiety	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
Restless Leg Syndrome	☐ Yes ☐ No	Hyperthyroidism	☐ Yes ☐ No
Heart		Hypothyroidism	☐ Yes ☐ No
Heart Attack Date _____	☐ Yes ☐ No	**Blood Disorders (Hematology)**	☐ Yes ☐ No
Angina/chest pain Date _____	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Abnormal sensations w/ exertion If yes, location (check one) ☐ Chest ☐ Arms ☐ Neck Date of last event _____	☐ Yes ☐ No	Blood Transfusion Date _____	☐ Yes ☐ No
High cholesterol/lipids	☐ Yes ☐ No	**Cancer/Malignancy**	
High blood pressure	☐ Yes ☐ No	Cancer Type _____	☐ Yes ☐ No
Irregular heart beat	☐ Yes ☐ No	Chemotherapy Date _____	☐ Yes ☐ No
Angioplasty/stent Date _____	☐ Yes ☐ No	Radiation Date _____	☐ Yes ☐ No
Can you walk two flights of stairs without stopping?	☐ Yes ☐ No	Surgery (breast cancer only) ☐ Right ☐ Left ☐ Bilateral	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	**Musculoskeletal**	
Swelling of the feet	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Rheumatic heart fever	☐ Yes ☐ No	Back/neck pain	☐ Yes ☐ No
Heart murmur/valve	☐ Yes ☐ No	TMJ/jaw pain	☐ Yes ☐ No
Pacemaker Last battery check _____	☐ Yes ☐ No	Artificial joint replacement Location _____	☐ Yes ☐ No
Implanted defibrillator	☐ Yes ☐ No	**Urological/Kidney**	
Lungs		Kidney disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Dialysis	☐ Yes ☐ No
Emphysema/COPD	☐ Yes ☐ No	Prostate disease	☐ Yes ☐ No
Chronic cough	☐ Yes ☐ No	(Female patients only) Last menstrual period _____	
Snoring/sleep apnea	☐ Yes ☐ No	I hereby attest that this information is true, accurate, and complete to the best of my knowledge.	
Do you use a CPAP device	☐ Yes ☐ No		
Pneumonia Date _____	☐ Yes ☐ No		
Recent cold or flu Date _____	☐ Yes ☐ No	_____	
Blood clot in lungs/legs	☐ Yes ☐ No	Patient Signature	