MEDICAL HISTORY

Reason for Today's Visit:_____

Questions You Would Like Answered Today:_____

List All Medications You Are Currently Taking Including Name & Dose of Medication:

1. _____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Please indicate if you have ever had any of the following:

Diagnosis:

___High Blood Pressure
___Heart Disease/Attack
___High Cholesterol
___Stroke/CVA
___Ulcers
___Reflux
___Emphysema
___Breathing Problems/COPD
__Asthma
___Anemia
___Clotting/Bleeding Problems
___DVT/Blood Clots/Phlebitis
___Arthritis/Joint Pain
___Osteoporosis
___Fractures/Broken Bones
___Gout
___Thyroid Disease
___Hepatitis
___HIV Disease
___Tuberculosis
___Depression
___Anxiety
___Kidney Disease/Urinary Issues
___Diabetes
___Cancer, Type_____

Symptoms:

___Unplanned Weight Loss
___Fevers
___Headaches
___Dizziness/Fainting
___Chest Pain
___Swelling of Arms/Legs
___Blurred Vision
___Hearing Loss
___Problems with Anesthesia

Other Disease or Problems Not Listed:_____ _____

_____

_____

Are You Allergic To Any medications or Latex? YES NO If Yes, please list

1._____ 2._____ 3._____
4._____ 5._____ 6._____

List All Surgeries You have had with an approximate date:_____

1._____ 2._____ 3._____
4._____ 5._____ 6._____

Have you ever been hospitalized for anything other the surgery? YES NO If yes, please list:_____

Reason: Date:

_____

_____

Has anyone in your family had any of the following?_____

____Heart Disease ____Diabetes ____Stroke ____High Blood Pressure ____Tuberculosis
____Clotting/Bleeding Problems ____High Cholesterol ____Problems with Anesthesia ____Cancer, Type_____

Are you **RIGHT** or **LEFT** handed? (Please circle one) What is your occupation?_____

Do you smoke? **YES** **NO** If yes, how much and for how long?_____ Are you interested in quitting? **YES** **NO**

Do you drink alcohol? **YES** **NO** If yes, how often and what is the amount?_____

Activities? (Hobbies or Sports) _____

I believe this information is true and complete to the best of my knowledge:

_____ _____
Patient Signature Date

Physician Notes:

_____

_____

_____