Date_____

Patient _____ Chart # _____

Date of Birth _____/_____/_____ Age _____

MEDICAL HISTORY

Please Print

PLEASE FILL OUT THE FOLLOWING INFORMATION COMPLETELY. IF YOU ARE UNSURE OF ANY INFORMATION REQUESTED, PLEASE BE SURE TO ASK YOUR PHYSICIAN AT THE TIME OF YOUR APPOINTMENT. PLEASE RESPOND TO EACH STATEMENT ANS ANSWER "N/A" IF APPROPRIATE. THANK YOU!

Height _____ Weight _____

Vision: Do you wear glasses? _____ Yes _____ No Contacts? _____ Yes _____No

Are you legally blind? _____ Yes _____ No _____ Rt. Eye _____ Left Eye _____ Both Eyes

Are you ALLERGIC to any MEDICATIONS and/or FOODS? _____ Yes _____ No If yes, please explain below.

_____
_____

Are you currently taking any MEDICATION? _____ Yes _____ No If yes, please list below.

_____
_____

Are you allergic to LATEX? _____ Yes _____ No If yes, have you been tested _____ Yes ____ No

Are you currently taking any medication that contains aspirin? _____ Yes _____ No If so, please circle any in this following list~Aspirin~Bayer~Excedrin~Ibuprofen~Advil~Neprin~Motrin or any other medication for Arthritis or Other: _____

Prior Surgeries? _____ Yes _____ No If Yes, Please list:_____
_____

Any Complications with Anesthesia? _____ Yes _____ No

Any significant illness as a child? _____ Yes _____ No
If Yes, Please explain: _____

Any significant illness as an adult? _____ Yes _____ No
If Yes, Please explain: _____

Any significant illness in your family? _____ Yes _____ No
If Yes, Please explain: _____

Do you smoke? _____ Yes _____ No If yes, how much per day? _____
Do you drink alcohol? _____ Yes _____ No If yes, How much per week? _____

PLEASE TURN THIS PAGE OVER AND COMPLETE THE MEDICAL INFORMATION

PLEASE CIRCLE THE APPROPRIATE RESPONE Y-YES N-NO U-UNSURE

AIRWAY

Capped, chipped, broken teeth	Y N U
Difficulty opening your mouth fully	Y N U

RESPIRATORY

Used tobacco within the year	Y N U
Persistent cough	Y N U
Sputum, phlegm, mucus production	Y N U
Asthma, wheezing	Y N U
Bronchitis, Emphysema, COPD	
Tuberculosis	Y N U
Shortness of breath after walking two	
Flights of stairs	Y N U
Recent cold	Y N U
Do you use a breathing device	Y N U
If yes, can you bring it with you that	
Day of surgery?	Y N U

HEART

Chest pain, angina, MI, heart attack	Y N U
Leg swelling, edema, CHF	Y N U
Paralysis	Y N U
High blood pressure	Y N U
Heart murmur, prolapsed mitral valve,	
Rheumatic fever	Y N U
Leg cramps when walking	Y N U

SKIN

Problems with wounds healing	Y N U
Scar badly	Y N U
Bruise easily, excessive bleeding	Y N U
Allergic reaction to adhesive tape	Y N U

ENDOCRINE

Diabetes, if yes will you need and insulin	
Order from your doctor	Y N U
Thyroid problems, heat or cold	
Intolerance	Y N U
Low blood sugar	Y N U

ABDOMEN

Hiatal hernia, frequent	
regurgitation, heartburn	Y N U
Ulcers, vomiting blood	
hepatitis, jaundice	Y N U
Liver disease, cirrhosis	Y N U
Kidney disease	Y N U

GENITOURINARY

Could you be pregnant	Y N U
Difficulty passing urine	Y N U
At risk for AIDS or venereal	
diseases	Y N U

MUSCULOSKELETAL

Physical limitations, appliances, or	
prosthesis	Y N U
Arthritis (jaw, neck, back)	Y N U
Phelebitis	Y N U

NEUROLOGICAL/PSYCHIATRIC

Seizures, convulsions, fainting,	
epilepsy	Y N U
Stroke, fleeting blindness or	
weakness	Y N U
Psychiatric treatment	Y N U
Anxious about possible surgery	Y N U

GENERAL

Headaches, unexplained	
weight loss	Y N U
Steroid use within 1 yr.	Y N U
Blood transfusion	Y N U
Have used recreation drugs	Y N U
Anemia or bleeding disorder	Y N U
Glaucoma	Y N U
Chemotherapy(w/in 6 months)	Y N U

If you answered YES to any of the above, please explain:

_____

_____

_____

_____