

Name: _____ Date: _____

DOB: _____

PATIENT MEDICAL HISTORY

Ht: _____ Wt: _____ **RACIAL ORIGIN** Page: 1
☐ White ☐ Black ☐ Hispanic ☐ Other:

Do you smoke or use tobacco products? ☐ YES ☐ NO
Quantity? _____ how many years _____ I quit ☐
Do you drink alcoholic beverages? ☐ YES ☐ NO Quantity? _____
Do you use recreational drugs? ☐ YES ☐ NO
Do you have bleeding tendencies? ☐ YES ☐ NO
Do you have dentures? ☐ YES ☐ NO
Loose/missing/broken teeth? ☐ YES ☐ NO

CHECK ALL CONDITIONS YOU HAVE HAD OR ARE BEING TREATED FOR

☐ NONE

- | | | | |
|--|--|---|---|
| ☐ High blood pressure | ☐ Macular degeneration | ☐ Prostate problem | ☐ Ulcer |
| ☐ Mitral valve prolapse | ☐ Colon polyps | ☐ Cirrhosis | ☐ Reflux |
| ☐ Stroke/TIA | ☐ High cholesterol | ☐ Cancer | ☐ Hepatitis |
| ☐ Paralysis | ☐ Heart attack | ☐ Endocarditis | ☐ HIV+/AIDS |
| ☐ Asthma | ☐ Pacemaker/defibrillator | ☐ Congestive Heart Failure | ☐ Rectal bleed |
| ☐ Shortness of breath | ☐ Seizures | ☐ Chest pain | ☐ Currently pregnant |
| ☐ Thyroid disease | ☐ Emphysema | ☐ Irregular beat | ☐ Kidney stones |
| ☐ Renal disease | ☐ Tuberculosis | ☐ Alzheimer's | ☐ Hypoglycemia |
| ☐ Sleep apnea | ☐ Diabetes | ☐ Tremors | ☐ Arthritis |
| ☐ Anemia | ☐ Hiatal hernia | ☐ COPD | ☐ Renal failure/dialysis |

OTHER: _____

Have you or any immediate family member experienced any anesthesia complications?

☐ YES ☐ NO Explain: _____

INDICATE ALL PREVIOUS SURGERIES

- | | |
|---|--|
| ☐ Heart bypass _____ vessels | ☐ Heart valve replacement |
| ☐ Pacemaker/defibrillator | ☐ Heart stents x _____ |
| ☐ Abdominal aortic aneurysm | ☐ Carotid endarterectomy ☐ Left ☐ Right |
| ☐ Splenectomy | ☐ Brain surgery |
| ☐ Lung resection ☐ Left ☐ Right | ☐ Organ transplant |
| ☐ Cervical laminectomy/fusion | ☐ Lumbar laminectomy/fusion |
| ☐ Total hip replacement ☐ Left ☐ Right | ☐ Total knee replacement ☐ Left ☐ Right |
| ☐ Colon resection | ☐ Rotator cuff repair ☐ Left ☐ Right |
| ☐ Hysterectomy | ☐ Prostatectomy |
| ☐ Mastectomy ☐ Left ☐ Right | ☐ Appendectomy |
| ☐ Gallbladder | ☐ Hernia repair ☐ Left ☐ Right |
| ☐ Cataract removal | ☐ Cesarean section |
| ☐ Other: _____ | ☐ Tonsillectomy |
| | ☐ NONE |

Family History: Do any medical problems run in your family?

☐ No ☐ diabetes ☐ high blood pressure ☐ glaucoma ☐ macular degeneration ☐ other

Do you have an Advanced Directive or Living Will? ☐ yes ☐ no

Review of Systems: Do you have any of the following symptoms? ☐ No

neurological problems (headaches, paralysis, numbness) _____
psychiatric problems (depression, anxiety, etc.) _____
chronic fever, unexplained weight loss / gain, fatigue _____
ear / nose / throat problems (hearing loss, sinus problems) _____
heart problems (chest pain, irregular heart beat) _____
respiratory problems (wheezing, shortness of breath) _____
urinary problems (pain, blood in urine, etc.) _____
gastrointestinal problems (diarrhea, vomiting, etc.) _____
skin problems (rashes, non-healing lesions, etc.) _____
musculoskeletal problems (joint pain, muscle aches) _____