

PATIENT MEDICAL HISTORY

The following information is very important in your care.
Please take the time to fill out this form completely and accurately.

Name _____ Date of Birth _____ Age _____

Sex: M F Height _____ Weight _____

Why are you seeing the doctor today?

Please list all surgeries or procedures you have had (list year if known)

Have you ever had problems with anesthesia in the past? Y N

If yes, what reaction did you have? _____

Medical History: Please tell us if you have any of the following. If yes, please explain.

Glaucoma	Y	N	Heart Disease	Y	N
Hard of Hearing	Y	N	High blood pressure	Y	N
Diabetes	Y	N	Pacemaker	Y	N
Arthritis	Y	N	Mitral Valve Prolapse	Y	N
Kidney disease	Y	N	Heart murmur	Y	N
Colon problems	Y	N	Irregular heart beat	Y	N
Cancer	Y	N	Artificial heart valve	Y	N
Bleeding problems	Y	N	Lung disease	Y	N
Seizure disorder	Y	N	Asthma/Lung disease	Y	N
Stroke or TIA	Y	N	Sleep apnea	Y	N

Explain: _____

Please list any other medical history not listed above: _____

(OVER)

Are you allergic to any medicines, latex or dyes? Y N

If so, please list them: _____

List all medication you are currently taking, including insulin, inhalers, or eye drops. (please include dose and how often taken): _____

Do you take Aspirin daily? Y N Coumadin? Y N

Do you smoke? Y N If yes, how much and how long? _____

If you have quit smoking, when? _____

Do you drink alcohol Y N If yes, how much? _____

Have you ever had a colonoscopy? Y N If so, when and where? _____

Do you have any family history of heart disease, diabetes, stroke or cancer?
(Please list) _____

Have you had a chest x-ray or an EKG in the past year? (If yes, please indicate when and where)

If you require any tests or surgery, which hospital do you prefer? Does your insurance require you to use a specific hospital? If so, which hospital? _____

Please return this form to the receptionist when you are done. Thank you.

" I attest that the information on this form is true and correct to the best of my knowledge."

Signature

Date