MEDICAL HISTORY AND QUESTIONNAIRE

Name:_____ **Date of Birth:**_____/_____/_____ **Age:**_____
Last Name First Name Initial

Sex: FEMALE / MALE **Height:**_____ **Weight:**_____

I. MEDICAL HISTORY

Do you have any of the following:

YES	NO	
☐	☐	High Blood Pressure
☐	☐	Heart Trouble –murmur, palpitations (arrhythmia), pacemaker
☐	☐	Chest pain (angina), heart attack, heart failure
☐	☐	Scarlet fever, rheumatic fever
☐	☐	Asthma, T.B., lung problems, shortness of breath with walking
☐	☐	Blood disorder, anemia, clotting problems, phlebitis
☐	☐	Seizure, epilepsy, convulsions
☐	☐	Fainting spells, blackouts, stroke
☐	☐	Frequent or severe headaches
☐	☐	Diabetes
☐	☐	Thyroid condition, goiter
☐	☐	Cancer
☐	☐	Jaundice, hepatitis, liver problems
☐	☐	Kidney, bladder problems
☐	☐	Poor wound healing, radiation treatment
☐	☐	Abnormal response to cold, Raynaud's disease
☐	☐	Rheumatoid arthritis, scleroderma, collagen disease, lupus
☐	☐	Skin pigment problems, keloid, poor scarring
☐	☐	Fever blisters, cold sores, herpes simplex
☐	☐	Frequent infections or boils
☐	☐	Blood transfusion
☐	☐	Significant emotional problems
☐	☐	Psychiatric care
☐	☐	Recent fever or cold

☐ ☐ Are you pregnant now? ☐ None; I have not and currently do not have these medical problems

II. PAST MEDICAL HISTORY

Have you had any illnesses of the following: (*please circle)*

Heart	Lungs	Kidneys	Chest	Stomach	Eyes
Ears	Nose	Throat	Brain	Intestines	Arms
Hands	Legs	Nerves	Reproductive System		

Operations/ Injuries: _____

Year General/ Local Anesthetic

III. RECENT EXAMINATIONS

	YES	NO	DATE
History and Physical	☐	☐	_____
Chest X-ray	☐	☐	_____
EKG (Electrocardiogram)	☐	☐	_____
Lab work	☐	☐	_____

IV. MEDICATIONS

Please list medications you take: _____

_____

Do you have allergies to medications (including latex, tape, dyes,etc):

YES NO

☐ ☐ If yes, please list _____

Are you taking or have you taken in the last 6 months any of the following:

YES	NO		YES	NO	
☐	☐	Aspirin or aspirin containing products?	☐	☐	Steroids, cortisone or ACTH?
☐	☐	Tranquilizers or sedatives?	☐	☐	Anticoagulants, blood thinners?
☐	☐	Insulin?			
☐	☐	Any over-the-counter drugs or herbal supplements, including aspirin, motrin, alleve, nuprin, ginko biloba, vitamin E?			

V. SOCIAL HISTORY

Approximate daily consumption of : Alcohol_____ Tobacco_____ Coffee_____

VI. FAMILY HISTORY

Has any relative ever had:

YES	NO		YES	NO	
☐	☐	Cancer, breast cancer	☐	☐	Diabetes
☐	☐	Epilepsy	☐	☐	Rheumatoid arthritis, scleroderma, lupus
☐	☐	Heart disease	☐	☐	High blood pressure
☐	☐	Lung disease, asthma	☐	☐	Kidney disease
☐	☐	Blood disease	☐	☐	Mental disease
☐	☐	Reaction to anesthesia			

VII. ANY OTHER INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW?

*If any of the above information changes, please inform the doctor.

Form completed by:_____

Date:_____ (Patient's Signature and Print Name)