



Personal Medical History

Name: _____ Date: _____

SOCIAL

Age: _____ Sex: M F Married/Partnered: Y N Occupation: _____

Responsible Adult Available to Assist During Recovery Period Y N Relationship: _____

HABITS

Smoke: Y N Amount: _____ Coffee/Tea/Cola: Y N Amount: _____

Alcohol: Y N Amount: _____ Daily Exercise: Y N Amount: _____

MEDICATIONS: List dose or number of pills per day

Prescription Drugs	Non Prescription (Vitamins; Herbs)
_____	_____
_____	_____
_____	_____

Regular Aspirin Use: Y N Dosage & frequency: _____

NSA (Advil, Motrin, Ibuprofen): Y N Dosage & frequency: _____

Cortisone Injections Past Year: Y N Date(s) and injection location: _____

Drug Allergy: Y N List drug(s) and type of reaction: _____

Latex Allergy: Y N Tape Allergy Y N

FAMILY HISTORY: Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y <input type="checkbox"/> N <input type="checkbox"/>	Coronary Surgery: Y <input type="checkbox"/> N <input type="checkbox"/>	Kidney Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Abnormal Clotting: Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes: Y <input type="checkbox"/> N <input type="checkbox"/>	Tuberculosis:	Y <input type="checkbox"/> N <input type="checkbox"/>
Anesthetic Problems: Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Attack: Y <input type="checkbox"/> N <input type="checkbox"/>	Other Serious Illness:	Y <input type="checkbox"/> N <input type="checkbox"/>
Cancer: Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension: Y <input type="checkbox"/> N <input type="checkbox"/>		

Please describe questions with a "Yes" answer: _____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding: Y <input type="checkbox"/> N <input type="checkbox"/>	Asthma: Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension: Y <input type="checkbox"/> N <input type="checkbox"/>
Abnormal Clotting: Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes: Y <input type="checkbox"/> N <input type="checkbox"/>	Sleep Apnea: Y <input type="checkbox"/> N <input type="checkbox"/>
Acid Regurgitation: Y <input type="checkbox"/> N <input type="checkbox"/>	Fainting Spell: Y <input type="checkbox"/> N <input type="checkbox"/>	Snoring: Y <input type="checkbox"/> N <input type="checkbox"/>
Anemia: Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Attack: Y <input type="checkbox"/> N <input type="checkbox"/>	Weight Change past 12 Mo.: Y <input type="checkbox"/> N <input type="checkbox"/>
Angina: Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis: Y <input type="checkbox"/> N <input type="checkbox"/>	Other Serious Illness: Y <input type="checkbox"/> N <input type="checkbox"/>

Please describe questions with a "Yes" answer: _____

Have you ever received a transfusion? Y N If yes, what year? _____

Have you been tested for HIV? Y N If yes, what year _____ Test results: positive negative

Do you wear: Contact lenses: Y N Eye glasses: Y N Hearing aid: Y N Dentures: Y N

Previous Surgery, year and type of procedure: _____

Indicate the type(s) of anesthesia received in the past, list any complications / reactions you experienced:

Local anesthesia - (complications/reactions): _____

General anesthesia -(complications/reactions): _____

Spinal / Epidural - (complications/reactions): _____

Date last seen by Primary Care Physician: _____

Primary Care Physician (name) _____ (telephone) (_____) _____

FEMALE PATIENTS: No. of pregnancies _____ No. of children _____ Last menstrual period _____ Did you breast feed? Yes No