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 ❑	N ❑	Coronary Surgery:	Y ❑	N ❑	Kidney Disease	Y ❑	N ❑
Abnormal Clotting:	Y ❑	N ❑	Diabetes:	Y ❑	N ❑	Tuberculosis:	Y ❑	N ❑
Anesthetic Problems:	Y ❑	N ❑	Heart Attack:	Y ❑	N ❑	Other Serious Illness:	Y ❑	N ❑
Cancer:	Y ❑	N ❑	Hypertension:	Y ❑	N ❑			

Please describe questions with a "Yes" answer: _____
_____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding:	Y ❑	N ❑	Asthma:	Y ❑	N ❑	Hypertension:	Y ❑	N ❑
Abnormal Clotting:	Y ❑	N ❑	Diabetes:	Y ❑	N ❑	Sleep Apnea:	Y ❑	N ❑
Acid Regurgitation:	Y ❑	N ❑	Fainting Spell:	Y ❑	N ❑	Snoring:	Y ❑	N ❑
Anemia:	Y ❑	N ❑	Heart Attack:	Y ❑	N ❑	Weight Change past 12 Mo.:	Y ❑	N ❑
Angina:	Y ❑	N ❑	Hepatitis:	Y ❑	N ❑	Other Serious Illness:	Y ❑	N ❑

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