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MEDICAL HISTORY

NAME: ______________________________ DATE:______________

Have you had any of the following medical problems?

PATIENT HISTORY			FAMILY HISTORY
No ______	Yes ______	1) Heart problems? (Heart attack, heart failure, irregular heartbeat)	Yes ________
No ______	Yes ______	2) Circulation problems or blood clots? ____________________	Yes ________
No ______	Yes ______	3) High Blood Pressure? ____________________	Yes ________
No ______	Yes ______	4) High cholesterol? ____________________	Yes ________
No ______	Yes ______	5) Anemia - low blood count? ____________________	Yes ________
No ______	Yes ______	6) Bleeding problems? (easy bruising)____________________	Yes ________
No ______	Yes ______	7) Do you use blood thinners? (Coumadin, Warfarin, Lovenox, Plavix)	
No ______	Yes ______	8) Do you use aspirin daily?	
No ______	Yes ______	9) Have you had a blood transfusion?	
No ______	Yes ______	10) Lung disease? (asthma, bronchitis, emphysema, shortness of breath)	Yes________
No ______	Yes ______	11) Tuberculosis? ____________________	Yes ________
No ______	Yes ______	12) Do you smoke?	
		If yes, packs per day_________how long?__________	
No ______	Yes ______	13) Diabetes? ____________________	Yes ________
No ______	Yes ______	14) Stomach problems or surgery? ____________________	Yes ________
No ______	Yes ______	15) Gallbladder problems or surgery? ____________________	Yes ________
No ______	Yes ______	16) Liver disease? (like hepatitis)____________________	Yes ________
No ______	Yes ______	17) Kidney problems or stones? ____________________	Yes ________
No ______	Yes ______	18) Bladder problems or urinary tract infections? ____________	Yes ________
No ______	Yes ______	19) Thyroid disease?____________________	Yes ________
No ______	Yes ______	20) Stroke? ____________________	Yes ________
No ______	Yes ______	21) Seizures or neurological problems? ____________________	Yes ________
No ______	Yes ______	22) Cancer? ____________________	Yes ________
No ______	Yes ______	23) Arthritis?____________________	Yes ________
No ______	Yes ______	24) Infection problems? ____________________	Yes ________
No ______	Yes ______	25) Herpes? ____________________	Yes ________
No ______	Yes ______	26) Joint replacements or implants?____________________	Yes ________
No ______	Yes ______	27) Do you drink alcohol? ____________________	Yes ________
If yes, Daily ________	Weekly______________	Rarely______________	
No ______	Yes ______	28) Do you use recreational drugs? ____________________	Yes ________
If yes, Daily ________	Weekly______________	Rarely______________	

PLEASE COMPLETE BOTH SIDES. THANK YOU.

PATIENT NAME______________________________

PREVIOUS SURGERIES

Year Type of Surgery

____

____

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List of Allergies to Any Medicines:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Are you Allergic to Latex Rubber? No ________Yes________

What Medicines Do You Take? (Including Aspirin)

Include hormones, birth control pills, and any herbal supplements. If you have a list of your medications, please give the list to our staff to make a copy. If you do not have a list, please write your medications in the space provided below.

Name of Medicine Dose How many times per day?

____

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