

**PATIENT MEDICAL HISTORY (Please answer ALL questions)**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ PCP: \_\_\_\_\_

REASON FOR CONSULT: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ Describe Recent Weight Change: \_\_\_\_\_

Allergies to medications and/or tape:	Reactions:	Allergies to Medications and/or tape:	Reactions:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current medications: (Including herbal meds & vitamins)	Reasons for taking them:	Current medications: (Including herbal meds & vitamins)	Reasons for taking them:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Usage of aspirin/aspirin products: YES \_\_\_\_\_ NO \_\_\_\_\_ How often? \_\_\_\_\_ Last time used? \_\_\_\_\_  
Usage of Ibuprofen: YES \_\_\_\_\_ NO \_\_\_\_\_ How often? \_\_\_\_\_ Last time used? \_\_\_\_\_  
Cigarette usage? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, how may? \_\_\_\_\_ and for how long? \_\_\_\_\_  
Alcohol usage? Never: \_\_\_\_\_ Rarely: \_\_\_\_\_ Occasionally: \_\_\_\_\_ Socially: \_\_\_\_\_ Daily: \_\_\_\_\_  
**Females:** Are you pregnant? YES \_\_\_\_\_ NO \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Ages of Chil(ren) \_\_\_\_\_

If you have EVER been treated for the following medical problems, please check and provide detail information:

_____ high blood pressure _____	_____ bleeding tendency _____
_____ stroke date: _____	_____ tendency to form wide scars _____
_____ heart disease/chest pain/pressure _____	_____ hepatitis _____
_____ irregular/fast/slow heart rates _____	_____ yellow jaundice _____
_____ mitral valve prolapse _____	_____ liver disease _____
_____ sleep apnea _____	_____ nasal airway problem _____
_____ psychological disorder _____	_____ facial injuries/paralysis _____
_____ lung problems _____	_____ sexually transmitted diseases _____
_____ asthma/chronic/exercise _____	_____ HIV/AIDS _____
_____ emphysema/bronchitis _____	_____ anemia _____
_____ tuberculosis (TB) _____	_____ collagen disorders _____
_____ seizures _____	_____ scleroderma _____
_____ epilepsy _____	_____ autoimmune disease/lupus _____
_____ fainting spells _____	_____ diabetes/type of treatment _____
_____ arthritis/bursitis _____	_____ thyroid problems _____
_____ cancer _____	_____ have you executed an advance directive _____
	_____ living will _____

**PATIENT MEDICAL HISTORY (page 2)**

**SURGICAL HISTORY/RADIATION THERAPY**

PROCEDURE	YEAR	COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ANTIBIOTICS: Do you normally take antibiotics before surgery, including dental surgery?      YES \_\_\_\_\_ NO \_\_\_\_\_

Explain: \_\_\_\_\_

Has any member of your family had any type of problem or complication with anesthesia?      YES \_\_\_\_\_ NO \_\_\_\_\_

Explain: \_\_\_\_\_

Explain any incidence of unexplained high fever, dark colored urine or malignant hyperthermia, in connection with anesthesia:

\_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I realize that accurate medical and social information is necessary for safe and proper medical care and have provided this information honestly and to the best of my ability.

Signature: \_\_\_\_\_  
(Patient or Guardian)

Date: \_\_\_\_\_

\_\_\_\_\_  
Doctor initial and date

I have reviewed my medical information given to me on the above date and have made the necessary changes.

Signature: \_\_\_\_\_  
(Patient or Guardian)

Date: \_\_\_\_\_

\_\_\_\_\_  
Doctor initial and date