SURGICAL AND MEDICAL HISTORY

PATIENT'S NAME____ **DOB**: ________________________________

PAST MEDICAL HISTORY: (PLEASE USE BLACK INK ONLY)
Have you or any member of your immediate family ever been diagnosed with any of the medical problems listed below? (please check)

PROBLEM:	Patient	Parents/Grandparents
NONE (if no problems)	____	____
AIDS/HIV	____	____
Asthma	____	____
Back problems	____	____
Bronchitis	____	____
Cancer (type__________)	____	____ (type________)
Chest pain / Angina	____	____
Convulsions / Epilepsy	____	____
Diabetes	____	____
Gestational diabetes	____	____
Emphysema	____	____
Gallbladder disease	____	____
Hay fever / Seasonal allergies	____	____
Heart attack	____	____
Heart murmur	____	____
Hiatal hernia	____	____
High blood pressure	____	____
Irregular heartbeat	____	____
Kidney Trouble / Dialysis	____	____

PROBLEM:	Patient	Parents/Grandparents
Jaundice at birth	____	____
Hepatitis / Liver trouble	____	____
Low blood pressure	____	____
Meningitis	____	____
Mononucleosis	____	____
MRSA	____	
Nervous Disorder / Breakdown	____	____
Peptic ulcer disease	____	____
Pneumonia	____	____
Polio / Paralysis	____	____
Pregnant (currently)	____	____
Reflux disease	____	____
Rheumatic fever	____	____
Sickle cell disease	____	____
Sleep apnea	____	____
Stroke	____	____
Thyroid disease	____	____
Tuberculosis	____	____
Other ___________________	____	____

HABITS:

SMOKING:

Do you currently smoke? _____Yes _____No
Have you ever smoked? _____Yes _____No
If yes to either of the above questions, how much (packs per day)? _____
Number of years smoked? _____
If you smoked and quit, how many years ago did you quit? _____
Have you recently quit smoking (< 1 year) _____Yes _____No

Do you chew tobacco? _____Yes _____No
Have you chewed tobacco in the past? _____Yes _____No
Do you smoke cigars? _____Yes _____No
Do you smoke a pipe? _____Yes _____No
Do you use snuff? _____Yes _____No
If yes to use of snuff or smokeless tobacco, for how long? ________
If you used snuff or smokeless tobacco & quit, when? ___________

ALCOHOL USE: _____NEVER DRANK
Do you drink alcohol (beer/wine/liquor)? _____Yes _____No

If so, how many drinks per day do you have? _____

Have you ever had a problem with alcohol? _____Yes _____No

RECREATIONAL DRUGS: _____NEVER USED
Do you use any recreational drugs? _____Yes _____No

If yes, name of drug(s): _________________________________

Have you ever used steroids? _____Yes _____No

If yes, name of drug(s): _________________________________

REVIEW OF CURRENT SYSTEMS

(Please indicate only current problems of patient)

____ **NONE (if no problems)**
____ Fever
____ Weight loss
____ Changes in hearing
____ Nasal obstruction/discharge
____ Voice changes/hoarseness
____ Lump in the neck
____ Visual loss
____ Diplopia (double vision)
____ Chest pain
____ Palpitations
____ Weakness of arms or legs
____ Tingling/numbness of hands or feet
____ Slurred speech
____ Difficulty sleeping
____ Intolerance to heat or cold
____ Shortness of breath
____ Wheezing
____ Nausea
____ Vomiting
____ Pains in joints
____ Skin problems
____ Difficulty with urination
____ Easy bruising
____ Abnormal bleeding
____ Lymph node enlargement
____ Rash/hives
____ Itchy eyes/nose
____ Depression
____ Mood changes

HEIGHT: __________

WEIGHT: __________

OVER →

PLEASE USE BLACK INK ONLY **SURGICAL AND MEDICAL HISTORY (CONTINUED)**

PATIENT'S NAME:____ **DOB**: ________________________________

OCCUPATIONAL HISTORY: Are you currently working outside the home? _____YES _____NO

If so, occupation? ____

SURGICAL PROCEDURES: _____ No surgery

1. Name of surgery: ____________________________________
   Date of surgery: ____________________________________
2. Name of surgery: ____________________________________
   Date of surgery: ____________________________________
3. Name of surgery: ____________________________________
   Date of surgery: ____________________________________
4. Name of surgery: ____________________________________
   Date of surgery: ____________________________________
5. Name of surgery: ____________________________________
   Date of surgery: ____________________________________
6. Name of surgery: ____________________________________
   Date of surgery: ____________________________________

Reaction to anesthesia? _____ Difficulty breathing _____ Difficulty awakening from surgery
_____ Nausea/vomiting _____ Other reaction to anesthesia

COMMENTS: ____

LIST OF CURRENT MEDICATIONS: **PREFERRED PHARMACY**: ____

ARE YOU CURRENTLY TAKING MEDICATIONS: YES______ NO______ (If yes, please list below.)
Please make sure to include over-the-counter medications, vitamins and herbal remedies.

	MEDICINE NAME	DOSE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

DO YOU HAVE ANY KNOWN ALLERGIES? YES______ NO______

Please list any allergies to medications below:

	MEDICINE NAME	REACTION
1.		
2.		
3.		
4.		

I have completed this medical history form and to the best of my knowledge it is complete and accurate. I understand that this document will be used for medical decision making and treatment. I hereby consent to treatment.

____ _____________

PATIENT SIGNATURE **DATE**