Medical History

Please thoroughly complete the following personal and health history information.

Patient's Name: _____ DOB ___ / ___ / _____ **Height** _____ **Weight** _____

Street Address: _____ City _____ State _____ Zip _____

Phone: Mobile _____ Home _____ Work _____

Responsible Party's Name _____ Relationship to Patient _____

Do you see a primary care physician regularly? **Yes** **No**

When was your last physical? _____

List all physicians and contact information _____

_____

_____

_____

List all current medications and dosages _____

_____

_____

Allergies (medications, food, latex) _____

Smoking/Tobacco Yes No **Pks:** **Yrs:**

Alcohol Use Yes No **Amount:**

Recreational Drug/Marijuana Use Yes No **Note:**

Do you snore? Yes No **Sleep study?** Yes No

Previous Operations/Anesthesia + Dates

_____

_____

Please list any history of:

1) **Heart conditions including high blood pressure, heart murmurs, shortness of breath, chest pain, palpitations, or a history of heart attack.**

2) **Lung conditions including asthma, COPD, bronchitis, or recent cold/flu/respiratory illness.**

3) **Stomach or abdominal conditions including reflux, nausea, or difficulty swallowing.**

4) **Endocrine conditions including diabetes, thyroid issues, or pancreatic problems.**

5) **Neurologic conditions including seizures, palsy, stroke, or ADHD.**

6) **Kidney and/or liver conditions.**

7) **Blood or coagulation conditions including anemia, poor or increased clotting, hemophilia, or HIV.**

8) **Hospitalizations and dates.**

Please use empty space on this form if more space is necessary to complete your health history.

I understand that the accuracy of my responses is critical to the safety of anesthetic management. I have carefully answered all questions to the best of my knowledge.

Signature _____ **Date** _____

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