

Name: _____ Age: _____

Occupation: _____ Family Doctor: _____

MEDICAL HISTORY *Do you have any medical problems with the following:* _____ Date: _____

	YES	NO
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Circulation	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	<input type="checkbox"/>
Urinary	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Explain: _____

1. Do you smoke? Yes No
How much?: _____

Do you drink (Alcohol)? Yes No
How much?: _____

2. Have you stopped smoking? Yes No
When?: _____

Number of Pregnancies: _____
Number of Children: _____

Allergies: _____

Date of Last Menstrual Period: _____
Have You or a Family Member had any problems
with Anesthesia? Yes No

Please List All Previous Surgery:

Explain: _____

Please List All Current Medications (include Prescription, Non Prescription IE. Birth Control, Aspirin):
Dosage Times/Day

Dosage Time/Day

Does your family have a history of the following
medical problems?:

Heart Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cancer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Permission is granted to release pertinent medical information for pending surgical procedure.

Patient Signature: _____