

Name: \_\_\_\_\_

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

**PAST MEDICAL HISTORY:** List all hospitalizations, operations, illnesses and injuries within the past 5 years:

- 1. \_\_\_\_\_ Year \_\_\_\_\_
- 2. \_\_\_\_\_ Year \_\_\_\_\_
- 3. \_\_\_\_\_ Year \_\_\_\_\_
- 4. \_\_\_\_\_ Year \_\_\_\_\_

**Circle any of the following if you still have, or have ever had:**

- |                       |                     |                  |                      |
|-----------------------|---------------------|------------------|----------------------|
| Heart Disease/Trouble | Sickle Cell Disease | Venereal Disease | Diabetes (Sugar)     |
| Heart Attack          | T.B.                | Jaundice         | Gout                 |
| High Blood Pressure   | Emphysema           | IV Drug Use      | Rheumatoid Arthritis |
| Stroke                | Lung Disease        | Hepatitis        | Osteoarthritis       |
| Seizures              | Chronic Bronchitis  | Polio            | Poor Circulation     |
| Mitral Valve Prolapse | AIDS/HIV Positive   | Psoriasis        | Rheumatic Fever      |

**DRUG HISTORY:** (No medications, please check \_\_\_\_\_)

List all medications (including dose and number taken per day) that you take daily.

- 1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

**ALLERGIES:** (No known allergies, please check \_\_\_\_\_)

List any known allergies including: **MEDICINES**, adhesive tape, or latex

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:**

What type of work do you do? \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_ How much? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much/often? \_\_\_\_\_

**MEDICAL HISTORY:**

- Do you bruise easily, bleed for a long time or have free bleeders in the family? ..... Yes No
- Have you ever had a problem with any anesthesia? ..... Yes No
- Have you ever been told you have a sugar problem? ..... Yes No
- Can you take aspirin? ..... Yes No
- Are you able to take Advil or Aleve without problems? ..... Yes No
- Do you ever get a burning pain in your stomach? ..... Yes No
- Women - are you pregnant now or possibility of being pregnant? ..... Yes No

**FAMILY HISTORY: (Circle any that runs in your family)**

- |                     |              |                     |          |
|---------------------|--------------|---------------------|----------|
| Heart Disease       | Stroke       | Sickle Cell Disease | Gout     |
| High Blood Pressure | Heart Attack | Cancer              | Diabetes |