Date_____ **MEDICAL HISTORY**(Please Print)

Name _____Age____ Height _____ Weight _____ Marital Status_____
Race _____ Family Doctor_____ Date of last physical _____
What duties do you perform at your job? _____ Are you RT or LT handed? _____
Please list any known drug allergies. _____
Are you allergic to latex? _____ Are you allergic to tape? _____ Do you take vitamins/supplements?_____
Please list any medications with doses you are currently taking _____
_____

Please check any illnesses or conditions that you or your family have a history of:

	Explain	Personal	Family
Cancer (list type of cancer)	_____	_____	_____
Diabetes		_____	_____
High Blood Pressure		_____	_____
Anesthetic Problems	_____	_____	_____
Heart Disease/Attack/Angina	_____	_____	_____
Stroke		_____	_____
Abnormal Bleeding		_____	_____
Abnormal Clotting		_____	_____
Anemia		_____	_____
Hepatitis		_____	_____
Glaucoma		_____	_____
Nervous Disorder		_____	_____
Kidney Disease		_____	_____
Asthma		_____	_____
Tuberculosis		_____	_____
Fainting Spell		_____	_____
Acid Regurgitation		_____	_____
Obstructive Sleep Apnea		_____	_____
Sexually transmitted diseases		_____	_____
Blood Transfusion when?_____		_____	_____
Other _____		_____	_____

Do you wear contacts?_____ Eyeglasses? _____ Dentures? _____ Hearing aids?_____ Piercings?____
Do you use tobacco products? _____ What kind? _____ How often? _____
Do you use alcoholic beverages? _____ What kind? _____ How often? _____
Do you use caffeine products? _____ How often?_____Do you exercise daily? _____
Do you take cortisone-containing drugs (steroids)? _____ Oral Contraceptives? _____
Aspirin or aspirin-like drugs (NSAIDS? _____Insulin? _____ Blood thinners (Coumadin/Plavix)? _____
Have you experienced a weight change over the past 12 months?_____ How many children do you have?_____
Have you ever been tested for the A.I.D.S. virus? _____ Year? _____ Result? _____ Other STD's?_____
Please list previous operations, serious illnesses, or broken bones
_____
_____
Previous Anesthesia type you have experienced_____ Problems?_____
Women patients only:
Is there a chance you are pregnant? _____Previous pregnancies? _____ Previous live births?_____
Last Menstrual Period _____ Did you breast feed?_____