PATIENT MEDICAL HISTORY

Name: _____ Today's Date: _____

REVIEW OF SYSTEMS:

Are you currently having or have you had any history of any of the following? (if yes, please explain)

Eyes: _____	Ears: _____	Nose: _____	Throat: _____
Lungs/Breathing: _____	Asthma: _____	Digestion: _____	Bowel Movement: _____
Bladder: _____	Diabetes: _____	Tuberculosis: _____	Polio: _____
High Blood Pressure: _____	Blackout/Fainting:_____	Dizziness: _____	Balance Problems: _____
Epilepsy: _____	Cardiac: _____	Pulmonary Embolism: _____	Thrombophlebitis: _____
Bleeding Problems: _____	AIDS/HIV: _____	Cancer: _____	Psychological Problems: _____

Do you have any Food or Drug Allergies? _____

Past Medical History (Any problem not listed above) _____
_____

Please list all current medications:

Medication Dose Reason Side Effects

_____
_____
_____

Past Surgical History:

Surgical Procedure Hospital Year Surgeon Any Complications

_____
_____
_____

Have you had General Anesthesia? Yes or No
Have you ever had any problems with Anesthesia? (general or local) Yes or No
If you answered yes to either question, please explain: _____

Social History:

Marital status: Single Married Divorced Separated
Employment status: Employed Student Retired Other: _____

Do you live alone? Yes or No
Do you exercise: Daily Weekly Monthly Rarely Never
Any history of substance abuse?: Yes or No If yes, what type?: _____
Do you currently smoke?: Yes or No If yes, how many packs a day? _____
Did you quit smoking?: Yes or No If yes, how many years ago? ___ Prev. smoked ____ packs/day, for ___ years
Do you drink alcohol?: Yes or No Daily _____ 1-2 times/week _____ 1-2 times/month _____
FEMALES ONLY: Is there any possibility of pregnancy? Yes or No Date of last menstrual cycle: _____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____