

# Medical History

<b>Name:</b>	_____		
<b>Procedure Scheduled:</b>	_____	<b>Date of Procedure:</b>	_____
<b>Birth Date:</b>	_____	<b>Age:</b>	_____
<b>Home Phone:</b>	_____	<b>Work Phone:</b>	_____
<b>Cell Phone:</b>	_____	<b>Email:</b>	_____
<b>Address:</b>	_____	<b>City, ST, Zip:</b>	_____
<b>Employer:</b>	_____	<b>Occupation:</b>	_____
<b>Emergency Contact:</b>	_____	<b>Phone:</b>	_____
<b>Relationship:</b>	_____		

## Past Medical History

<input type="checkbox"/> Any Bleeding Problems	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood Clots in Lungs / Legs
<input type="checkbox"/> Deep Vein Thrombosis/ DVT	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> HIV
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Mobility / Joint Problems	<input type="checkbox"/> Neurological Problems
<input type="checkbox"/> Oral Herpes	<input type="checkbox"/> Personal or Family History of Breast Cancer	<input type="checkbox"/> Problems Urinating or Urethral Stricture	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Sexually Transmitted Disease(s)	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Vision Problems
<b>Explanation to any of the above:</b>			
_____			
_____			
_____			
_____			
_____			
_____			

# Past Medical History

List any surgeries and/or medical illnesses - include date(s)	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____			
_____			
Do You Smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	Date Started:
Do You Use Alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	
Have you ever had problems with anesthesia in the past (ie. Difficulty breathing, Nausea, etc...)?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____			
Do you have any questions regarding anesthesia?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Question: _____			
Do you object to a blood transfusion for any reason?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Explain (optional): _____			

Signature of Patient: \_\_\_\_\_

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