

MEDICAL INFORMATION

Name _____ Date _____

Please briefly explain the reason for this visit: _____

Drug Allergies _____

Latex Allergy: No _____ Yes _____ Blood test drawn to verify latex allergy No _____ Yes _____

Current Medications _____

List any vitamins or herbal supplements: _____

Have you or any member of your family have a bleeding problem? No _____ Yes _____

List all medical conditions: _____

List all previous hospitalizations: _____

List all operations: _____

Have you had any problems with a previous operation or anesthesia? No _____ Yes _____

Have you experienced any of the following medical conditions? If yes, please explain.

Yes No Chest pain or pressure: _____

Yes No Shortness of breath: _____

Yes No Asthma or wheezing: _____

Yes No Frequent and Severe Headaches: _____

Yes No Nausea and/or vomiting: _____

Yes No Dizziness _____

Yes No Fainting _____

Yes No Seizures: _____

Yes No Weight loss: _____

Yes No Changes in vision: _____

Yes No Swelling in legs or feet: _____

Yes No Blood Clots: _____

Yes No Circulation Problems: _____

Yes No Heart murmur _____

Yes No History of Rheumatic Fever: _____

Yes No Sinus Problems: _____

Yes No Diabetes: _____

Yes No Hypertension: _____

Yes No Stroke: _____

Yes No Hepatitis: _____

Yes No Renal Disorders: _____

Yes No Cancer: _____

Yes No Sexually Transmitted Disease: _____

Yes No Keloids: _____

Yes No Wound Healing Problem: _____

Yes No MRSA _____

Yes No Burning, Itchy or dry eyes: _____

Yes No Excessive Tearing: _____

Yes No Snoring: _____

Yes No Sleep Apnea: _____

Yes No Depression: _____

Yes No Anxiety: _____

Yes No Do you smoke? Packs per day x # of years: _____

Yes No Do you consume alcohol? Daily consumption: _____

Family History:	Yes	No	Which Family Member(s)
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Stroke	_____	_____	_____
Bleeding Problems	_____	_____	_____
Blood Disorders	_____	_____	_____
Cancer	_____	_____	_____
Problems w/Anesthesia	_____	_____	_____