



## MEDICAL HISTORY

In an effort to serve you better, we request that you provide us with the following information. All information is held strictly confidential and is released only with your written consent.

Last Name	First	Age	Sex	Referring Physician
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Presenting Problem or Proposed Surgery

**Physician Notes**  
*please do not write in this area*

**ILLNESS/INJURY:** Please check if you have ever had:

Yes	No		Yes	No	
		High blood pressure			Gallstones
		Diabetes			Kidney stones
		Peptic ulcers			Bleeding problems
		Heart attack			Diverticulosis
		Chest pain/tightness			Thyroid problems
		History of heart murmur			Lung problems/asthma
		Stroke			Shortness of breath
		Cancer			Accidents/broken bones (list)
		Hepatitis			
		Yellow jaundice			

**OPERATIONS:** Please list operations you have had.  NONE

Year	Name of Operation	Type of Anesthetic, if known	Complications

Have you ever had a blood transfusion?  Yes  No Date \_\_\_\_\_  
 List any hospital admissions or medical conditions not listed above:  
 \_\_\_\_\_  
 \_\_\_\_\_

**DRUGS:** Please list all drugs you take and their dosages.  NONE

Drug	Dosage	Drug	Dosage

**ALLERGIES:** Please list type and reaction.  NONE

Name of Drug	Reaction	Name of Drug	Reaction

Do you smoke or have you ever smoked?  No  Quit: \_\_\_\_\_ mo./yrs. ago  
 Yes: \_\_\_\_\_ packs/day x \_\_\_\_\_ years  
 Do you drink alcohol?  No  Yes-rarely/occasionally/daily: \_\_\_\_\_ drinks/day  
 Have you ever been a heavy drinker?  No  Yes, how long ago? \_\_\_\_\_  
**FEMALES ONLY:** Are you pregnant?  Yes  No

The above information is true and accurate. (Parent signature required if patient is a minor.)  
 Patient Signature \_\_\_\_\_ Date \_\_\_\_\_