Medical History

Pink Ink

Name: ____ **Date:**________________

Best phone number to contact you: ____________________________________

Age_______ Sex: M F Marital Status: S M D W

Occupation:____

Primary Care Physician:_______________________________

Habits: Alcohol: Y N
Smoke: N Y, ______ packs per day; N , but I quit in _______ (year)

Medications: List dose or number of pills per day

Prescription Drugs	Non Prescription (OTC; Vitamins; Herbs)

Regular Aspirin Use: Y N Dosage & frequency: __________________
NSAID (Advil, Motrin, Ibuprofen, Naproxen, Aleve): Y N
Dosage & frequency: __________________

Latex Allergy: Y N
Tape/Adhesive Allergy: Y N
Egg Allergy: Y N
Drug Allergy: Y N
If yes, list drug(s) and type of reaction: ____

Medical History (Circle all that apply)

Lungs: **No Problems** Bronchitis Asthma Shortness of Breath Cough Wheezing Emphysema Tuberculosis

Cardiovascular: **No Problems** Blood Clot Hypertension Heart Attack Pacemaker Leg Swelling/Leg Ulcers Murmur Anemia Irregular Heart Beat Mitral Valve Prolapse

Gastrointestinal: **No Problems** Bleeding Stools Vomiting Reflux Ulcers Nausea

Endocrine/ID: **No Problems** Thyroid Disorder Diabetes Adrenal Growth Hormone Abnormality Pituitary Disorder HIV Hepatitis: *A B C*

ENT: **No Problems** Ear Infections Nasal Polyps Sinus Problems Oral Ulcerations Tumors Dentures Sleep Apnea

Medical History (continued)

Oncology: **No Problems** History of Cancer (Type: ________________________)

Rheumatology: **No Problems** Lupus Arthritis Scleroderma Limited Motion

Opthamology: **No Problems** Cataracts Contacts Glasses Eye Allergies
Dry Eyes Glaucoma Lasik Surgery Double Vision

Neurologic: **No Problems** Seizures Numbness Nerve Palsy Migraine Headache
Fainting Stroke

Musculoskeletal: **No Problems** Bone Fracture(s) Hip Replacement Back Injury Neck Injury

Skin: **No Problems**

History of Skin Cancer? Y N
Melanoma: Basal Cell: Squamous Cell Cancer:

Do you heal poorly i.e. keloids/hypertrophic scarring? Y N
Do you bruise easily? Y N
Do you sunburn easily? Y N
Do you develop rashes from the sun? Y N
Do you have a history of cold sores? Y N
Do you suffer from eczema or psoriasis? Y N
Do you have any type of skin disorders? Y N
Do you have varicose veins? Y N
Do you require antibiotics before surgery? Y N

Any Medical Problems not listed above?____________________________________

Past Surgeries & Procedures:

Year:	Type:

Complications/reactions to anesthesia you experienced:
*Local anesthesia____
*General anesthesia____

FEMALE PATIENTS ONLY:

Do you think/know you are pregnant? Y N