# MEDICAL HISTORY

NAME:

DATE OF BIRTH:

Present Medications (Name & Dose):

Allergies (Medication Name):

Previous Operations (When and Where):

Previous Hospitalizations (When and Where):

Have you ever smoked? Yes ☐ No Most you ever smoked?_____packs/day. How many years?_____If you quit when_____.

Do you drink alcohol? ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

Do you use recreational drugs? ☐ Yes ☐ No Have you ever used intravenous drugs? ☐ Yes ☐ No

PLEASE INDICATE **YES** OR **NO** TO THE FOLLOWING QUESTIONS:

| Have you ever had… | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Heart problems | | | Thyroid problems | | | Stroke | | |
| High blood pressure | | | Kidney problems | | | Venerael disease | | |
| Irregular pulse | | | Hepatitis, jaundice | | | High risk act for AIDS | | |
| Chest pain/angina | | | Hiata Hernia, Heartburn | | | Steroid treatments | | |
| Respiratory problems | | | Ulcers | | | Alcohol or drug addiction | | |
| Asthma | | | Bleeding problems | | | Special diet | | |
| Fainting | | | Transfusions | | | Tuberculosis | | |
| Seizures/Epilepsy | | | Anemia | | | Difficulty urinating | | |
| Numbness or weakness | | | Arthritis | | | History of childhood abuse | | |
| Diabetes | | | Back pain | | | HIV infection | | |
| Could you be pregnant? | | | Neck stiffness | | | "Alternative" treatments | | |

EXPLANATION OF ABOVE OR OTHER MEDICAL PROBLEMS:

| FAMILY HISTORY | Living | Age now or at time of death | Well | Cause of illness or death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Sibling | | | | |
| Spouse | | | | |
| Children | | | | |
| | | | | |
| | | | | |
| | | | | |

| HAS ANY BLOOD RELATIVE? | YES | NO | IF YES INDICATE WHO? |
|---|---|---|---|
| Had early heart disease? | | | |
| Been an alcoholic/addict? | | | |
| Had gout? | | | |
| Had unusual bleeding tendencies? | | | |
| Had death during anesthesia? | | | |

I HAVE READ AND ANSWERED THESE QUESTIONS TO THE BEST OF MY KNOWLEDGE.

Signature of patient or legal guardian: Date: