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Name_____ **Age**_____ **Todays Date** _____ (update date)_____

Patient Medical History Form

List current and prior medical problems

☐ **Hypertension**	☐ **Diabetes**	☐ **Kidney Failure**
☐ **Heart disease**	☐ **Hypothyroid**	☐ **Stroke**
☐ **Arrythmia_____**	☐ **Hyperthyroid**	☐ **Seizure Disorder**
☐ **Emphysema**	☐ **Vascular disease**	☐ **Migraines**
☐ **Asthma**	☐ **Bleeding disorder**	☐ **Cirrhosis**
☐ **Ulcers**	☐ **Anemia**	☐ **Liver Disease**
☐ **Gastroesophageal Reflux Disease**		☐ **Inflammatory Bowel**
☐ **History of Colon polyps**		☐ **Diverticulitis**
☐ **Benign Prostatic Hypertrophy**		
☐ **Arthritis [ ]** osteo **[ ]** rheumatoid		
☐ **Cancer** _____		
☐		
☐		

List Previous Surgeries

Operation Performed	**Year**	**Location**	**Surgeon**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any medication allergies below and the reaction you had

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Medications

Medication	Dose	Frequency	Over the Counter Medication	Dose	Frequency

Marital Status_____ **# of Children**_____ **Type of Employment**_____

Do you smoke? [ ] yes [ ] no How much? _____packs/day Quit _____yrs ago
Do you drink? [ ] yes [ ] no Type _____ How much? _____ ozs/day
Illegal drugs? [ ] yes [ ] no Type _____ [ ] current [ ] past

Please list any illnesses that run in your family

☐ **Cancer** *type*_____
☐ **Heart Disease** ☐ **Diabetes**
☐ **Bleeding disorder** ☐ **Anesthetic Complication**
☐ **Colon Polyps** ☐ _____

Check if you have or have had any of the following:

☐ **Stroke**	☐ **Chest pain**	☐ **Difficulty breathing**
☐ **Weakness on one side**	☐ **Irregular heart beat**	☐ **Cough**
☐ **Slurred speech**	☐ **Heart Failure**	☐ **Wheezing**
☐ **Loss of Vision**	☐ **Heart Attack**	☐ **Pneumonia**
☐ **Numbness or tingling**	☐ **Swelling of the legs**	☐ **Bronchitis**
☐ **Fainting spell**	☐	☐ **Sleep Apnea**
☐ **Abdominal Pain**	☐ **Peptic ulcers**	☐ **Difficulty voiding**
☐ **Heartburn**	☐ **Liver failure**	☐ **Urinary frequency**
☐ **Difficulty swallowing**	☐ **Jaundice**	☐ **Burning with urination**
☐ **Diarrhea**	☐ **Hepatitis**	☐ **Urinary tract infections**
☐ **Constipation**	☐ **Light colored stools**	☐ **Urinary incontinence**
☐ **Nausea/Vomiting**	☐ **Blood in stools**	☐ **Reproductive problems**
☐ **Poor appetite**	☐ **Fecal incontinence**	☐ **Prostate problems**
☐ **Low back pain**	☐ **Bleeding Problems**	☐ **Anesthetic Difficulty**
☐ **Joint pain**	☐ **Anemia**	☐ **Dentures**
☐ **Weakness**		
☐ **Pain in legs with walking**	☐ **Pain in legs at rest**	☐ **Weight loss/gain**
☐ **Ulcers on the feet or legs**	☐ **Varicose Veins**	_____**lbs** _____**mos**