## General Medical History

Height: ______ Weight: ______ BMI: ______ Right / Left Handed (Circle one)

Please list any **ALLERGIES or REACTIONS** to **Latex**, **Iodine**, **Metal** or any **Medication**: ☐ I have none of these allergies

| | | |
|---|---|---|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

Please list all **MEDICATIONS including herbal supplements** that you are **currently taking**: ☐ Check box if separate list provided

| | | |
|---|---|---|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

Please list all previous **SURGERIES** you have ever had (please give approximate dates and the surgeon's name)

| | | |
|---|---|---|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

| Medical History (Check all that Apply): | No | Yes | | | No | Yes |
|---|---|---|---|---|---|---|
| High Blood Pressure | ____ | _____ | | Bleeding disorder / Anemia | _____ | _____ |
| Heart Attack / Coronary Artery Disease | ____ | _____ | | Intestinal Bleeding / Ulcer | _____ | _____ |
| Irregular Heart Beat | ____ | _____ | If yes, do you have a pacemaker? Yes / No | Hyperthyroidism | _____ | _____ |
| Stroke / Paralysis / Seizures | ____ | _____ | | Hypothyroidism | _____ | _____ |
| Blood Clots / Pulmonary Embolism | ____ | _____ | If yes, when? ____________________ | Liver Failure / Cirrhosis | _____ | _____ |
| Diabetes | ____ | _____ | If yes, what is your hemoglobin A1c? _____ | AIDS/HIV | _____ | _____ |
| Rheumatoid Condition | ____ | _____ | If yes, please describe: ________________ | Tuberculosis | _____ | _____ |
| Kidney Disease / Failure | ____ | _____ | If yes, are you on dialysis? Yes / No | Hepatitis | _____ | _____ |
| Cancer | ____ | _____ | If yes, what type: ____________________ | Asthma/ Emphysema | _____ | _____ |
| Organ Transplant | ____ | _____ | If yes, what type: ____________________ | Reaction to Anesthesia | _____ | _____ |

Family History (Check all that Apply):

| | No | Yes | | No | Yes | | No | Yes | | No | Yes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes | _____ | _____ | Stroke | _____ | _____ | Bleeding Disorder | _____ | _____ | Reaction to Anesthesia | _____ | _____ |
| Heart Attack | _____ | _____ | Blood Clot | _____ | _____ | Pulmonary Embolism | _____ | _____ | Cancer | _____ | _____ |

Social History:

Do you **smoke tobacco?** ___No ___Yes ___Quit?

If yes, how many cigarettes per day? ____________________ If you quit smoking, when did you quit? ____________________

Do you use **recreational drugs** (including marijuana)? ___No ___Yes If yes, please describe: ______________________________

Do you **drink alcohol?** ___No ___Yes If yes, number of drinks per day or per week? ______________________________

Do you play any sports or what do you do for **exercise**? ______________________________

Systems Review:

Have you had any of the following problems **recently**?

| | No | Yes | Description (If yes, please describe and indicate if it has been resolved.) |
|---|---|---|---|
| Cold or flu? | ______ | ______ | ______________________________ |
| Skin problems? | ______ | ______ | ______________________________ |
| Eye/ear problems? | ______ | ______ | ______________________________ |
| Nerve problems? | ______ | ______ | ______________________________ |
| Heart problems? | ______ | ______ | ______________________________ |
| Breathing problems? | ______ | ______ | ______________________________ |
| Bleeding problems? | ______ | ______ | ______________________________ |
| Intestinal problems? | ______ | ______ | ______________________________ |
| Urinary problems? | ______ | ______ | ______________________________ |
| Depression/anxiety? | ______ | ______ | ______________________________ |
| Dental problems/infections? | ______ | ______ | ______________________________ |

By signing below, I certify that my provided health history information is true and complete to the best of my knowledge.

**Patient Signature:** ________________________________________ **Date:** ______________