Medical Information

Present Illness / Condition

What type of exam/consultation are you here for:

Any Recent Emergency Room visits?

Symptom(s) Describe:
Date(s) of onset:
Location (Where on body symptom occurs):

Health History - Have you ever been treated for any of the following? *Circle all that apply.*

Cardiac / Heart Disease
- Atrial Fibrillation
- Chest Pain
- Congestive Heart Failure
- Heart Disease
- High Cholesterol
- High Blood pressure
- Mitral Valve Prolapse
- Pacemaker / ICD
- Pulmonary Hypertension
- Rheumatic Heart
- Rhythm disturbances
  Specify:
- None

Cancer or Tumor
- Type_____

- Skin Cancer
  Melanoma
- Breast

Endocrine
- Diabetes - Circle:
  Diet / Pill / Insulin / Pump
- Thyroid Problems / Goiter
- Adrenal disease
- None

Respiratory
- Asthma
- Bronchitis
- Difficulty breathing
- Emphysema / COPD
- Hoarseness
- Pneumonia
- Sleep Apnea
  CPAP - Y / N?
- Snoring
- History of smoking
- None

Neurological/Mental Health
- Stroke
- Stroke Mini (TIA)
- Epilepsy or Seizures Disorders
- Migraine headaches
- Chemical dependency
- Myasthenia Gravis
- Depression / Anxiety
- Emotional Illness
- Claustrophobia
- Panic attack
- Learning Disabilities
- None

Bleeding Circulation
- Anemia
- Bleeding tendency
- Blood clots
- Poor circulation
- Sickle Cell
- None

Genitourinary
- Kidney disease
- Kidney Stones
- Prostate/testicle problem
- Urinary Tract Infection
- Difficulty urinating
- None

Gastrointestinal
- Hernia
- Gallbladder
- Gastric Reflux
- Intestinal Blockage
- Liver Disease
- Intestinal or Gastric Ulcers
- Difficulty swallowing
- None

Musculoskeletal
- Arthritis
- Gout
- Limited movement
- Multiple sclerosis
- Back / neck Problems
- Polio
- None

Hearing & Vision
- Hearing loss
- Hearing Aide
- Glasses
- Contacts
- Glaucoma
- Cataract
- None

Implantable Devices
- Dialysis Port / Pump
- Other Ports/Pumps
- Pacemaker/ICD
- Other (list)

Important!

Infectious Diseases
- HIV
- Hepatitis
- MRSA
  Tuberculosis
- VRE
- C Diff

Skin
- Rashes
- Sore/Open areas
- Skin Ulcer
  Where? _____
- None

	Bring implant card with you.		
Have you been hospitalized for any of the above conditions? **Date(s)?** **Hospital Name, City State:**			

Surgical History - Check all that apply & Specify Date(s)

□ No prior surgery □ Angioplasty □ Appendectomy □ Arthroscopy □ Breast Biopsy □ Heart Bypass	□ Cataract □ Colon / Intestinal □ D & C □ Gallbladder □ Heart Catheter □ Heart Valve replaced	□ Hemorrhoidectomy □ Hernia □ Hysterectomy □ Kidney removal □ Mastectomy L R □ Pacemaker	□ Prostate □ Spine (Back/Neck □ Splenectomy □ Tonsils & Adenoids □ Total Hip L R □ Total Knee L R	□ Tubal Ligation List any other: _____ _____ **Date(s)**_____ _____

ALLERGIES?		**Specify (List each)**	**Reaction(s) – Be specific**
Medications	□ Yes No	**Penicillin**	
Latex	□ Yes No		
Food	□ Yes No	Seafood Nuts	
Other	□ Yes No	Adhesive	

Are you on any MEDICATIONS?		**Specify (List each or Circle). List Medication & Dose**
Aspirin / Baby Aspirin	Yes No	
Antidepressants	Yes No	
Blood pressure pills	Yes No	
Blood thinner	Yes No	
Cholesterol	Yes No	
Eye drops	Yes No	
Fluid (water) pills	Yes No	
Heart pills	Yes No	
Herbal remedies/ Vitamins	Yes No	
Inhalers	Yes No	
Prednisone/Steroids	Yes No	
Other Medications ?	Yes No	

Family History (Close blood relatives): Check all that apply

☐ Cancer:_____ _____ _____	☐ Bleeding/Clotting Problems ☐ Diabetes	☐ Heart Disease ☐ High Blood Pressure	☐ Kidney Disease ☐ Mental Illness ☐ Neurological	☐ Thyroid Disease ☐ Tuberculosis

If yes to any above, Specify relationship:

Anesthesia History	**Yes**	**No**	**Explain (*specify: nausea, vomiting, other)***
Have you ever had anesthesia?			
Have you ever had a problem with anesthesia including malignant hyperthermia or difficult intubation?			
Has any member of your family had a problem with anesthesia?			
Loose, capped or broken teeth: bridges or dentures?			
Trouble opening mouth or jaw clicking?			
Do you exercise regularly?			If yes: low / moderate / active
Do you have shortness of breath after walking up 2 flights of stairs?			
Do you smoke?			#packs per day_____ # years_____
Are you an ex-smoker? When stopped?			
Do you drink alcoholic beverages?			Frequency_____ how much_____
Do you use any street drugs?			
Have you ever had a blood transfusion?			If "yes", what year(s)?
Do you have objections to receiving blood transfusions?			
Do you have problems with chronic pain?			
Any religious/cultural practices we should know about?			
Females Only – Is there any chance you could be pregnant?			Last Menstrual Period? _____

Additional Notes: _____

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_____

Patient Signature _____ Date _____

If Legal Guardian, Relationship to Patient _____