



Patient Medical History

Patient Name: Last First MI Preferred Name

Please check if you have ever had:

- Stroke
- Blood Clotting Disorder
- Heart Ailment
- Pacemaker
- High Blood Pressure
- Low Blood Pressure
- High Cholesterol
- Artificial Heart Valves
- Infective Endocarditis
- Total Joint Implants
- Pins/Plates/Screws
- HIV/AIDS
- Donor Organs
- Head/Jaw Injury
- Epilepsy/Seizures
- Fainting
- Liver Disease
- Hepatitis/Yellow Jaundice
- Diabetes
- Kidney Disease
- Stomach/Intestinal Disease
- Reflux
- Sexually Transmitted Disease
- Other
- Respiratory Disease
- Asthma
- Seasonal Allergies
- Sinus Problems
- Tumor/Cancer
- Radiation TREATMENTS
- Chemotherapy
- Thyroid Problems
- Rheumatism/Arthritis
- Osteoporosis Treatment
- Snore/Sleep Apnea

Please check if you have any of the following allergies/sensitivities:

- Latex
- Nickel/Jewelry
- Penicillin
- Codeine
- Sulfa

Other

Do you use tobacco?

- Yes
- No

If yes, which of the following

- Cigarettes
- Chewing Tobacco
- Cigars

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How long/Use per day

For Women Only

Birth Control Pills Pregnant Nursing

If pregnant, due date

Are you under medical treatment or have you had any major operations in the past 5 years?

Alerts

Current Medications, Dosage & Purpose:

Physician's Name & Phone Number

Response Date: