

Personal Medical History

	Yes	No	Details <i>(Please give details for all "yes" responses.)</i>
General: weight loss, fever, chills, nausea, vomiting			
Heart problems heart attack, heart failure, heart rhythm disturbance, chest pain, palpitations, leg pain			
Allergy Symptoms: Congestion, sneezing, itching, runny nose			
High Blood Pressure			
Lung problems asthma, COPD, cough, wheezing, shortness of breath			
Cancer			
Thyroid or endocrine problems			
Neurologic problems stroke, seizures, trauma, weakness, numbness			
Skin: lesions, moles, rashes			
Kidney or bladder problems			
GI problems stomach, intestine, colon, heartburn, abdominal pain			
Diabetes or blood sugar problems			
Infectious Diseases Hepatitis, HIV, fungal			
Psychiatric problems			
Physical Disability			
Bleeding / bruising problems			
Problems with Anesthesia For you or a family member			

• Have you ever had surgery? *(If yes, please list surgeries and approximate dates.)*

• Please list all medications you take on a regular basis. *(Include inhalers, aspirin, steroids, and diabetes medicines, if applicable.)*

Name of Medication and Dosage

• Are you allergic to any medications? *(If yes, list medication and what happened when you took it.)*

• Do you smoke tobacco? Yes / No / Quit For how long? _____ years _____ packs /day _____ pack-yrs

• Do you drink alcohol in any amount? Yes / No / Quit Usual beverage _____ _____ per day/wk/month

• Please list significant Family Medical History. *(Includes hearing loss, thyroid, diabetes, cancer, heart disease)*
