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HISTORY

Patient Name: _____ Date: _____
Reason for Visit: _____ Weight: _____ Height: _____ Age: _____

CURRENT AND PAST MEDICAL HISTORY: Please circle **Y**-yes or **N**-no.

Y or N Arthritis/Lupus/Rheumatoid Arthritis/Other Autoimmune Disease
Y or N High Blood Pressure
Y or N Epilepsy or Seizures
Y or N Blood Transfusion
Y or N Blood Thinners – If yes, name and dosage _____
Y or N GI Disorders: Diverticulitis, ulcers, colitis, Crohn's disease, other? _____
Y or N Lung Disease: Emphysema, COPD, asthma, tuberculosis, valley fever, pneumonia? _____
Y or N Cancer - If yes, what type? _____
Y or N Kidney Disorder - If yes, what type? _____
Y or N Heart Disease - If yes, what type? _____
Y or N Pacemaker - If yes, what type? _____
Y or N Anemia, Blood Disorder, Blood Clots - If yes, what type? _____
Y or N Diabetes - If yes, when were you diagnosed? _____
Y or N Hepatitis - If yes, what type? _____ **When were you diagnosed?** _____
Y or N Stroke - If yes, when? _____ **Any residual effect?** _____
Y or N Do you have any risk factors for AIDS or HIV? If yes, please explain _____
Y or N History of Mental Illness - If yes, please explain _____
Y or N Alcohol or Drug use? If yes, drinks/week: _____ **Type of drugs:** _____
Y or N Prior Alcohol or Drug use - If yes, please explain _____
Y or N Do you smoke? If yes, packs/day: _____
When did you start? _____ **When did you quit?** _____
Y or N Have you had MRSA? If yes, when? _____ **Where on your body?** _____
Y or N Thyroid Disease: Hyperthyroid Hypothyroid
Y or N Glaucoma: Macular Degeneration Legally Blind
Any Other Medical Issues: _____
Y or N Do you have problems with general anesthesia or bleeding/clotting?
If yes, please explain _____
Y or N Have you had any prior surgeries?
If yes, please list procedures and dates: _____

Y or N Are you taking any medication?
If yes, please list with dosages: _____

Y or N Are you allergic to any medications?
If yes, please list drug and type of reaction: _____
Y or N Are you allergic to any Latex?

Please list any **family history** of Cancer, Diabetes, Heart Disease, High Blood Pressure, Bleeding or Anesthesia Problems?

_____
_____
_____
_____