Name:
Date of Birth:
Reason for Visit:

Patient Past Medical History								
	No	**Yes**		**No**	**Yes**		**No**	**Yes**
Anema			Easy Bleeding/Bruising			Pacemaker/Defibrillator		
Arthritis			Eczema			Seizures		
Asthma			Heart Disease			Skin Cancer		
Anxiety			Heart Murmur			Skin Disease		
Bleeding Disorder			Hepatitis			Stroke		
Breast Cancer			High Blood Pressure			Thyroid Disorder		
Cancer			High Cholesterol/Lipids			Tuberculosis		
Chest Pain/Tightness			Hives			Ulcers		
COPD			Kidney Stones			Urinary Tract Infection		
Depression			Migraines			X-Ray Therapy		
Diabetes			Osteoporosis					

Patient Past Surgeries/Hospitalization (if none, please write none)				
Surgery/Hospitalizaion	**Date**	**Anesthesia Complications**	**Notes**	
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Patient Family History

	No	**Yes**	**Afflicted Family Member**
Abnormal Bleeding			
Abnormal Clotting			
Adopted			
Anesthesia Problems			
Autoimmune Disorder			
Brain Tumor			
Hemophilia			
High Blood Pressure			
Kidney Disease			
Liver Disease			
Lung Cancer			

Patient Family History - Continuation

	No	Yes	Afflicted Family Member
Breast Cancer			
Cleft Lip			
Cleft Palate			
Depression			
Diabetes			
Drug Allergies			
Endocrine Disease			
Hearing Loss			
Heart Disease			
Malignant - Hyperthermia			
Other Cancer			
Ovarian Cancer			
Prostate Cancer			
Seizures			
Skin Cancer			
Skin Disease			
Substance Abuse			
von Willebrand			

Allergies (if none, please write none)		
Allergies	**Reaction**	**Notes**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Current Medications (if none, please write none)		
Drug	**Dosage**	**Prescribed By**
1		
2		
3		
4		
5		
6		
7		
8		
9		