



Today's Date

PAST MEDICAL INFORMATION

Name of Patient _____ Age _____ Sex _____ Birth Date _____

Medical Conditions: (check if applicable) *IMPORTANT: CHECK AND/OR LIST ALL YOUR MEDICAL CONDITIONS*

Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/>	All other medical conditions not listed:
High Cholesterol <input type="checkbox"/> Heart Disease <input type="checkbox"/>	
Cancer <input type="checkbox"/> Osteoporosis <input type="checkbox"/>	
DVT/PE <input type="checkbox"/> Hypothyroidism <input type="checkbox"/>	

List Your Medications:

Are you **allergic** or **sensitive** to any medications or other substances? YES NO Metals Latex

If so, please list allergy and reaction: _____

Have you ever had general anesthesia? NO YES Have you or your family ever had any problems with anesthesia? NO YES

Past Surgical History: Have you ever been operated on for any condition? YES NO

Procedure	Date	Procedure	Date
Orthopedic		Hernia Repair	
Tonsillectomy		Gall Bladder	
Cataracts		Hysterectomy	
Appendectomy		C Section	
Bladder/Prostate		Cardiac/Bypass Surgery/Heart Catheter	
Other		Other	

Review of Symptoms:

Are you (or the child) having or have you had the following symptoms or problems with: **circle symptom if applicable or circle None**

Constitutional:	None	Fatigue	Fever	Weight Loss	Chills	Sweating
Eyes:	None	Blurred Vision	Glasses	Watering Eyes		
Ear/Nose/Mouth/Throat:	None	Sinus Pressure	Hearing Loss	Nose Bleeds	Sores in Mouth	
Respiratory:	None	Shortness of Breath	Wheezing	Cough	Coughing up Blood	
Cardiovascular:	None	Chest Pain	Palpitations	Tightness in Chest	Swelling	
Gastrointestinal:	None	Nausea	Vomiting	Constipation	Diarrhea	Change in Bowel Habits
Genitourinary:	None	Urinary Tract Infection	Difficulty Urinating	Incontinence	Loss of Sensation near groin/buttocks	
Endocrine:	None	Heat or Cold Intolerance	Excessive Thirst	Excessive Urination		
Musculoskeletal:	None	Joint Pain	Leg Pain	Joint Stiffness	Back Pain	History of broken bones
Hematologic/Lymphatic:	None	Anemia	Bruises Easily	Enlarged Glands	Prolonged bleeding after cut/injury	
Neurologic:	None	Numbness/tingling	Dizziness	Headaches	Frequent Falls	
Integumentary/Skin:	None	Rashes	Change in Skin Color			
Psychiatric:	None	Change in Mood	Anxiety	Confusion	Depression	Memory Loss
Allergies/Immunologic:	None	Asthma	Chronic Rashes	Hay Fever		

Social History:

Occupation: _____

Do you currently smoke? NO YES Have you ever smoked? NO YES If yes, how long ago did you quit? _____

Do you consume any alcohol? NO YES If yes, how often? _____

Single Married Divorced Widowed #of children _____

Is there a **family history** of: High Blood Pressure Heart Disease Diabetes Cancer Hyperthermia DVT/PE None

I certify to the best of my knowledge that the above information is correct.

Patient/Guardian Signature _____ reviewed _____

Date: _____

I have reviewed and agree with the findings as noted. Physician Signature: _____