

LAST NAME: _____ FIRST NAME: _____ Middle initial: _____

Please mark all that apply to your **PAST MEDICAL HISTORY:** D.O.B. _____

High blood pressure		Low blood pressure		Renal disease	
Infection		Diabetes		Nephritis	
Rheumatic Fever		Generalized Nervousness		Asthma	
Depression		Nervous breakdown		Heart disease	
Ulcer(s)		Arthritis		Cancer	
Colitis		Allergies		Other:	

Please mark all that apply to your **FAMILY HISTORY:**

Diabetes mellitus		Tuberculosis		High blood pressure	
Stomach ulcers		Kidney disease		Heart disease	
Ulcerative Colitis		Gallstones		Cancer	
Rheumatic Fever		Arthritis		Other:	
Allergies		Stroke			

Please list any previous **SURGERIES** that you have had: _____

Is there a family history of bleeding disorders or anesthesia problems? Yes _____ No _____
If yes, please explain: _____:

	Living:	Age:	Deceased:	Age:	Cause of death:
Mother					
Father					
Sisters:					
Brothers:					

Please mark all the **SYMPTOMS** that apply to you:

Headache(s)		Ringing in ears		Chest pain without exertion	
Vision difficulties		Difficulty hearing		Constipation	
Shortness of breath		Chest pain with exertion		Muscle pain	
Diarrhea		Sour stomach/heartburn		Other:	
Menstrual difficulties		Joint pain			

Present Complaints: _____

Please mark all that apply to your **HABITS:**

	Yes	No	Amount/Day
Cigarettes			# of packs
Beer			# of cans/bottles
Liquor			# of shots
Wine			# of glasses
Caffeine			# of cups/glasses

Exercise habits (i.e. activity/frequency)	Known Drug Allergies:

PRESENT MEDICATIONS: _____

Signature: _____ Date: _____