MEDICAL HISTORY FORM PAGE 1

MEDICAL HISTORY

Anxiety	Y	N	Hematologic Disorder (bleeding disorder)	Y	N	***Never a Smoker***	( )
Arthirits	Y	N					
Atrial Fibrillation	Y	N	High Cholesterol	Y	N	***Current Smoker***	YES NO
ASCVD	Y	N	High Blood Pressure	Y	N	how much: _____	
Asthma	Y	N	Kidney Disease	Y	N	how long: _____	
Bell's Palsy	Y	N	Migraines	Y	N	***Former Smoker***	Yes NO
Bleeding History	Y	N	Mitral Valve Prolapse	Y	N	How much: _____	
Cancer	Y	N	Obesity	Y	N	when did you quit?_____	
COPD (emphysema)	Y	N	Osteoporosis	Y	N	***How long did you smoke for?*** _____	
CVA (stroke)	Y	N	Parkinson's Disease	Y	N	***Caffeine***	YES NO
Dementia	Y	N	Pneumonia	Y	N	how much: _____	
Depression	Y	N	Pulmonary Embolism	Y	N	***Alcohol***	YES NO
Diabetes	Y	N	Seizures	Y	N	how much: _____	
Diverticulitis of Colon	Y	N	Sleep Apnea/Snoring	Y	N	***Other tobacco use***: _____	
Arterial Thrombosis	Y	N	Thrombophlebitis	Y	N		
DVT (leg blood clots)	Y	N	Thyroid Disorders	Y	N	***Any recent travel?***	YES NO
GERD/Indigestion	Y	N	TIA	Y	N		
Glaucoma	Y	N	Trouble w Anesthesia	Y	N	***CURRENT MED LIST***	
HIV	Y	N	Varicose Veins	Y	N	_____	
Hepatitis	Y	N	Vascular Disease	Y	N	_____	
						_____	

SURGICAL HISTORY

Anal Surgery	Y	N	Pacemaker Placement	Y	N	_____	
Appendectomy	Y	N	Defibrillator	Y	N	_____	
Bariatric Surgery	Y	N	Pilonidal Cyst Resection	Y	N	_____	
Breast Surgery	Y	N	Hysterectomy	Y	N	_____	
Cardiac Surgery	Y	N	Orthopedic Surgery	Y	N	_____	
Cardiac Cath & Stent	Y	N	Prostatectomy	Y	N	***ANY DRUG ALLERGIES***: _____	
Cesarean Section	Y	N	Spinal Surgery	Y	N	_____	
Cholecystectomy	Y	N	Tubal Ligation	Y	N	_____	
(gallbladder) date: _____			Thorax Surgery	Y	N	_____	
Colonoscopy	Y	N	Thyroid Surgery	Y	N		
What year: _____			Tonsillectomy	Y	N	***CURRENT PHARMACY***:_____	
Fractures	Y	N	Vasectomy	Y	N	_____	
GI Surgery	Y	N	**What kind of Orthopedic Surgery:			***City***: _____	
Hemorrhoid Surgery	Y	N	_____			***Phone#*** _____	
Hernia Surgery	Y	N	_____				

Date of last mammogram: _____ Any other previous surgeries? _____

Name: _____ ***DOB***: _____

Chief complaint:_____ ***Location of problem***: _____

Severity of problem: _____ ***When did the problem start?*** _____