Patient Medical History Form

Last name _____ First name _____
Date of birth _____
Address_____
City _____ State _____ Zip _____
Phone number _____
Email _____

Age_____ Sex ☐ Female / ☐ Male Height_____ Weight_____

Medical conditions:

High blood pressure	☐ Yes / ☐ No	Liver disease	☐ Yes / ☐ No
Heart disease	☐ Yes / ☐ No	Hepatitis	☐ Yes / ☐ No
Vascular disease	☐ Yes / ☐ No	Kidney disease	☐ Yes / ☐ No
Diabetes	☐ Yes / ☐ No	Seizures	☐ Yes / ☐ No
Thyroid disease	☐ Yes / ☐ No	Psychiatric disorders	☐ Yes / ☐ No
Lung disease	☐ Yes / ☐ No	HIV	☐ Yes / ☐ No
Shortness of breath	☐ Yes / ☐ No	Bleeding disorders	☐ Yes / ☐ No

Other conditions not listed _____
Have you recently been under the care of a physician for any reason ☐ Yes / ☐ No

Previous surgeries (and when) ☐ None
_____
_____
_____

Medications (and dosage) including herbal supplements ☐ None
_____
_____
_____

Allergies ☐ None
_____

Social habits

Tobacco products	☐ Yes / ☐ No	How much/often _____
Alcohol	☐ Yes / ☐ No	How much/often _____
Drug use	☐ Yes / ☐ No	How much/often _____

Personal or family history of problems with anesthesia ☐ Yes / ☐ No
Do you have sleep apnea ☐ Yes / ☐ No
Personal or family history of bleeding disorders or clots ☐ Yes / ☐ No
Is it possible for you to get pregnant ☐ Yes / ☐ No / ☐ NA

Preferred pharmacy (address and phone) _____

What would you like to discuss today
_____
_____

Signature _____ **Date** _____