Medical History Form

Patient Name: _____ Sex: M / F Birthdate: _____

Height: _____ Weight: _____ Age: _____ Phone: _____

Allergies: ☐ Latex Allergy	**Medications**:
Previous Surgeries:	
Personal / Family history of problems with anesthesia: ☐ Yes ☐ No	

NEURO/MUSCULOSKELETAL

- ☐ **None**
- ☐ TIA/Stroke/Residual Effects
- ☐ Seizure
- ☐ Autism/ADHD
- ☐ Down Syndrome
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Back/Neck Problems
- ☐ Muscular Disorder / Dystrophy

CARDIOVASCULAR

- ☐ **None**
- ☐ HTN
- ☐ CHF
- ☐ Coronary Disease
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Hyperlipidemia
- ☐ Blood Clot in Legs or Lungs
- ☐ Murmur / Congenital Defects
- ☐ Ankle Swelling
- ☐ Stents
- ☐ Arrhythmia
- ☐ Pacemaker
- ☐ Defibrillator

PULMONARY

- ☐ **None**
- ☐ Smoke
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ COPD
- ☐ Recent Cold within 2 weeks
- ☐ Sleep Apnea/ CPAP use

ENDOCRINE

- ☐ **None**
- ☐ Diabetes insulin dependent
- ☐ Diabetes non-insulin dep.
- ☐ Hypo/hyper thyroid disease
- ☐ Steroid Use
- ☐ Autoimmune Disease

GENITOURINARY

- ☐ **None**
- ☐ Renal Disease

For Women

- ☐ Pregnant? Yes / No
- ☐ Hysterectomy/Post Menopause
- ☐ Last Menses Started _____
- ☐ Birth Control / Tubal Ligation

GASTROINSTESTINAL

- ☐ **None**
- ☐ Gastritis
- ☐ Acid Reflux
- ☐ Slow Gastric Emptying
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Morbid Obesity
- ☐ Liver Disease/Cirrhosis

INFECTIOUS DISEASES

- ☐ **None**
- ☐ Hepatitis B / C
- ☐ TB Exposure
- ☐ HIV

SOCIAL

- ☐ **None**
- ☐ Regular Alcohol use
- ☐ Recreational Drugs use
- ☐ Other

BLOOD DISORDERS

- ☐ **None**
- ☐ Abnormal Bleeding Disorder
- ☐ Blood Thinner Use
- ☐ Anemia / Sickle Cell

AMBULATORY AIDS

- ☐ **None**
- ☐ Wheel Chair
- ☐ Walker / Cane
- ☐ Crutches

I understand that the accuracy of this medical history is critical for the best anesthesia outcome. Therefore by signing below, I attest that I have carefully answered all questions truthfully and to the best of my knowledge.

X_____

Patient Or Legally Responsible Person **Relationship to Patient** **Date**