

Medical History Record

Name: _____ Date: _____

Age: _____ Referred by: _____ Family Physician: _____

Reason for visit (Chief Complaint): _____

Date symptoms first appeared: _____

PAST HISTORY:

Previous surgeries: _____

Anesthetic/surgical problems: _____ Number of children born: _____

Personal Medical History (circle YES or NO):

yes/no - high blood pressure

yes/no - ulcer disease or abdominal problems

yes/no - heart disease or attack

yes/no - hepatitis

yes/no - chest pain or shortness of breath

yes/no - HIV

yes/no - stroke

yes/no - diabetes

yes/no - asthma

yes/no - Tubal Ligation

yes/no - glaucoma

yes/no - Hysterectomy

yes/no - fainting or blackout episodes

yes/no - other significant illness (kidney, thyroid, seizures) If so, describe _____

yes/no - Have you taken ibuprofen/aspirin in the past two weeks? (Avoid for two weeks prior to surgery)

yes/no - Do you have prolonged bleeding when cut? (Hemophilia)

yes/no - Have you formed excessive or unsatisfactory scars in the past? Keloids?

Current Medications (list all including aspirin and birth control):

Medications

Dose/Strength

Frequency taken

FAMILY HISTORY: (circle YES or NO)

yes/no - Any anesthetic problems _____

yes/no - Hepatitis _____

yes/no - High blood pressure _____

yes/no - Heart Attack _____

yes/no - Diabetes _____

yes/no - Cancer (skin) _____

yes/no - Any bleeding problems

yes/no - Other cancers (type) _____

(Hemophilia) _____

yes/no - Psychiatric disorders _____

SOCIAL HISTORY: (circle YES or NO)

yes/no - Do you smoke? _____ packs per day

yes/no - Did you ever smoke?

yes/no - Do you drink alcohol? daily _____ occasionally _____

To my knowledge the above information is complete and accurate.

Date

Signature

MD initials _____

Date _____