MEDICAL HISTORY

Name _____

Are you currently under a doctor's care? ..... Y____ N____
Doctor's name _____ Last examination _____
Have you had a heart, blood vessel, lung, kidney or joint replacement surgery? ..... Y____ N____
Have you been hospitalized in the last two years? ..... Y____ N____
Why? _____
Have you taken any medication in the last six months? ..... Y____ N____
(circle) high blood pressure, insulin, heart, tranquilizers, blood thinner, steroids, aspirin, asthma, Parkinsons, DIET medication, other *(list)* _____
Do you have any allergies? ..... Y____ N____
(circle) Ibuprofen, aspirin, codeine, penicillin, Keflex, other *(list)* _____
Do you smoke (pipe, cigar, cigarettes)? Packs per day? ____ For how long? _____ ..... Y____ N____
Have you or any member of your family had a bad experience with a general or local anesthetic? .. Y____ N____
Women: Are you or could you be pregnant? Months? _____ ..... Y____ N____
Do you use any recreational drugs? ..... Y____ N____
Have you or anyone in your immediate family ever had tuberculosis? ..... Y____ N____
Do you have a persistent cough lasting more than two weeks? ..... Y____ N____
Have you been tested for tuberculosis in the last 3 years? ..... Y____ N____
Have you been tested for HIV? ..... Y____ N____
Have you ever had radiation or chemotherapy? ..... Y____ N____

Have you ever taken Coumadin, Warfarin, Plavix, Xarelto, Pradaxa or Eliquis? ..... Y____ N____
Have you ever taken Fosamax, Actonel, Boniva, Zometa, Aredia or Reclast? ..... Y____ N____
Have you ever taken Fen-Phen or Redux? ..... Y____ N____

Have you had any of the following? *(please check the appropriate boxes)*

Y/N		Y/N		Y/N		Y/N	
☐☐	alzheimers	☐☐	cold sores/fever blisters	☐☐	heart murmur	☐☐	obstructive sleep apnea
☐☐	anemia	☐☐	decreased blood pressure	☐☐	heart problem	☐☐	pneumonia
☐☐	angina / chest pain	☐☐	depressive disorder	☐☐	heart valve surgery	☐☐	radiation therapy
☐☐	arthritis	☐☐	diabetes	☐☐	hepatitis	☐☐	rheumatic fever
☐☐	asthma	☐☐	emphysema / COPD	☐☐	high blood pressure	☐☐	scarlet fever
☐☐	bleeding tendency	☐☐	excessive bruising	☐☐	jaundice	☐☐	seizure disorder
☐☐	blood disorder	☐☐	glaucoma	☐☐	joint replacement	☐☐	sinus problems
☐☐	cancer	☐☐	glomerulonephritis	☐☐	kidney disease	☐☐	smokers cough
☐☐	chemotherapy	☐☐	heart attack	☐☐	liver disease	☐☐	stroke / TIA
☐☐	chronic bronchitis	☐☐	HIV/AIDS	☐☐	lung disease	☐☐	ulcer
						☐☐	venereal disease

Do you have: *(circle)* unexplained weight loss, weakness, fatigue, malaise, night chills, sweats, fever? . Y____ N____
Have you had recent: *(circle)* nasal discharge, sore throat, cold, cough? ..... Y____ N____
Do you have difficulty carrying on normal activities without shortness of breath or undue fatigue? .... Y____ N____
Do you rest after climbing one flight of stairs? ..... Y____ N____
Do your ankles swell as the day progresses? ..... Y____ N____
Have you awakened at night short of breath? ..... Y____ N____
Must you remain in a sitting position in order to breathe comfortably? ..... Y____ N____
Do you use more than one pillow for breathing comfort while sleeping? ..... Y____ N____
Have you experienced chest pain with physical activity? ..... Y____ N____
When you breath, can you hear a wheezing sound? ..... Y____ N____
Can you ever feel your heart beat, jump, flutter or seem irregular? ..... Y____ N____
Do you wish to speak privately with the doctor about anything? ..... Y____ N____

Signature _____ **Date** _____