

## MEDICAL AND SURGICAL HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Current Physician: \_\_\_\_\_

### ◆ PERSONAL MEDICAL HISTORY

**Medical Allergies:** \_\_\_\_\_

Please list all medications you are currently taking, including vitamins, birth control pills, aspirin, diet pills, herbal supplements, and any health food store over the counter supplements.

Exercise regularly? YES/NO      What exercise do you do? \_\_\_\_\_

Any chance that you may be pregnant? YES/NO      Date of your last menstrual period? \_\_\_\_\_

Are you a smoker? YES/NO      < 1ppd   1ppd   2ppd   Ex-smoker? YES/NO      When? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_

Have you ever used (circle): LSD / speed / cocaine / marijuana      Never

### ◆ FAMILY HISTORY

Have you or anyone in your family ever had problems with anesthesia? YES/NO

Who? What happened? \_\_\_\_\_

Any Family History of                      Heart Disease                      Lung Disease                      Other

Describe \_\_\_\_\_

### ◆ PERSONAL SURGICAL HISTORY

Please list all surgeries or hospitalizations you have had (including plastic surgery).                      Date



### Do you have or have you had any of the following?

	YES    NO    YEAR				YES    NO    YEAR		
Heart Attack				Bleeding tendency			
High Blood Pressure				Depression			
Irregular Heartbeat				Mental Illness			
Chest Pain (angina)				Seizures			
Abnormal EKG				AIDS/HIV positive			
Mitral Valve Prolapse				Blood Clots in legs / lungs			
Asthma or wheezing				Dry eyes			
Bronchitis				Glaucoma			
Emphysema				Steroid treatment			
Shortness of Breath				Other (please describe)			
Diabetes							
Kidney problems							
Liver disease (hepatitis)							
Heart burn or reflux							

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_