



Patient Medical History

Name: _____ Date of Birth: _____

Please tell us what procedures you are interested in:

Height: _____ Weight: _____

Do you Smoke? No Yes, How many packs per day? _____

How much alcohol do you drink?

None Occasional Social Daily More than 2 drinks a day more than 7 drinks a day

Do you have any allergies? Please list the medication or allergen and type of reaction:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Are you currently taking any vitamins, minerals or supplements?

No Yes, (please list type and dosage)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Are you currently taking any medications? No Yes, (please list type, dosage and frequency)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Do you have a history of any of the following bleeding problems?

Easy bleeding Von Willebrands Hemophilia Excessive clotting
History of DVT History of PE Anemia Anticoagulation
Other _____

Do you have problems with chronic dry eye which requires eye drops? No Yes

Have you had Lasik surgery within the last six months? No Yes

Do you wear contact lenses? No Yes

Have you had a history of any of the following?

General History:

Recent weight gain Recent weight loss Poor nutrition Chronic fatigue
Other _____

Psychiatric/ Neurologic History:

Seizures Depression Anxiety Fibromyalgia Other _____

Ear/Nose/Throat History:

Blepharospasm Hearing loss Wear glasses Vision loss Snoring/Apnea other _____

Cardiac History:

HTN Hyper cholesterol CHF Myocardial infarction Arrhythmias Pacemaker
Mitral Valve Prolapse Other _____

Pulmonary History:

Asthma PTX COPD Emphysema Other _____ Sleep Apnea Use CPAP

Hepatic History:

Hepatitis A Hepatitis B Hepatitis C Cirrhosis Jaundice
Gallstones Other _____

Renal History:

Kidney stones Renal Insufficiency Renal failure Pyelonephritis
Urinary tract infection Other _____

Gastrointestinal History:

Bleeding Ulcers Constipation Diverticulosis GERD Non-Bleeding Ulcers Hemorrhoids
Irritable bowel Other _____

Pregnancy history:

Vaginal Delivery, How Many? _____ C-Section Delivery, How Many? _____
Recurrent UTI Incontinence Urethral Stricture Other _____

Extremity History:

Varicose veins Chronic Edema Ulcers Difficulty Walking Other _____

Breast History:

Breast Mass, Left or Right Nipple Discharge, Left or Right History of Breast Feeding
Intertriginous Rashes Other _____

Endocrine History:

Diabetes, diet controlled Diabetes, oral medication
Diabetes, insulin dependent Hyperthyroid Hypothyroid Other _____

Infectious Disease History:

HIV Oral herpes Genital Herpes Genital warts Other _____

Anesthesia History:

Difficult Intubation Difficult Extubation Post-Op Nausea/Vomiting Malignant Hypothermia Other

Cancer History:

Skin Breast Lung Liver Colon Other _____

Other Health History Not Mentioned Above: _____

Does anyone in your family have a history of the following?

Abnormal bleeding Anesthesia Problems Autoimmune Disorders Cancer Diabetes Heart Disease
Kidney Disease Liver Disease Lung Disease Endocrine Disease Other _____

Past Surgical History:

Cosmetic surgery type and date: _____

Other surgery type and date: _____

Patient's Signature

Date