MEDICAL/SURGICAL HISTORY

Azita Madjidi, MD, MS, PA

Patient Name: Today's Date:

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information:

Age: Height: Weight Occupation:

Please list **ALL** medications which you are currently talking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications).

Medication (s): Amount: Frequency:

List all drug allergies:

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

Are you a smoker? YES/NO Ex-Smoker? YES/NO Non-Smoker? YES?NO

How much were you smoking? How long? Quit how long ago?

How much alcohol do you drink? Caffeine?

Please circle all of the medical conditions you have or have had in the past:

Bleeding tendency	Hepatitis	Diabetes	Blood transfusion	Glaucoma
Dry eyes	Lung disease	TB	Asthma or wheezing	Emphysema
Irregular heart beat	Bronchitis	Chest pain	Heart disease	Heart attack
Stroke	Epilepsy	Heart burn	Intestinal Ulcers/bleeding	Depression
Mental illness	Drug or alcohol addiction		or any other serious illness or injury	
		None of the above		

Is there any possibility that you may be pregnant at this time? YES/NO

List ALL surgeries that you have had (include plastic surgery):

Date:

Have you or anyone in your family ever had unusual reaction to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fever)? YES/NO

Do you have (circle): loose or chipped teeth/caps/dentures/contact lenses/none

Have you ever seen a cardiologist? YES/NO Physician's name: Date of last ECG:_____

Signature: _____ **Date**: _____