



## Medical History

Name \_\_\_\_\_

Date \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs

### Prior Surgeries

	Date _____	Type of Surgery _____

### Hospitalizations

	Date _____	Reason for Hospitalization _____

### Have you had any of the following medical conditions in the past 5 years? *(please check all that apply)*

- |   |  |   |  |  |
|---|--|---|--|--|
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Heart Trouble                   | <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nervous Breakdown   |
| <input type="checkbox"/> Angina           | <input type="checkbox"/> Stroke                          | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Jaundice                        | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Blood Transfusion   |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> AIDS/HIV                        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Black Stools    | <input type="checkbox"/> Blood in Urine      |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Cancer <i>(list type)</i> _____ |   |  |  |

### Medical History

Are there any other medical conditions or medical history not listed above? *(Please explain)*

\_\_\_\_\_

\_\_\_\_\_

Have you or a family member had a reaction to anesthesia?  yes  no

Have you or a family member had abnormal bleeding from surgery?  yes  no

### Medications

Name of Medication _____	Dosage _____	Frequency _____

### Have you taken any of the following in the last 6 months?

- Steroids     
  Aspirin/Advil     
  Blood Thinners     
  High Blood Pressure

### Allergies

\_\_\_\_\_

### Have you ever had a problem or reaction with any of the following?

- Local Anesthetics   
  Adhesive Tape   
  Antibiotics   
  Pain Killers   
  Iodine   
  Latex

### Tobacco History

Cigarettes   
  Cigar   
  Pipe   
  Chew   
 # Years using \_\_\_\_\_   
 Packs/day \_\_\_\_\_

### Family Physician

\_\_\_\_\_ Date of last checkup \_\_\_\_\_

### For Women Only

Date of your last period \_\_\_\_\_ Date of last mammogram \_\_\_\_\_

Are you pregnant?  yes  no      # of Children \_\_\_\_\_      # births \_\_\_\_\_

Family history of breast cancer?  yes  no