

PATIENT HEALTH HISTORY

Patient name _____ Birthdate _____ SS# _____

PAST MEDICAL HISTORY

General Health: Good _____ Fair _____ Poor _____ If not "Good" please explain _____

Do you Smoke? Yes _____ No _____ How many packs a day? _____

PREVIOUS SURGERY (Please List)

Operation	Hospital	Date	Anesthesia	Surgeon
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Complications After Surgery: Yes _____ No _____ Explain _____

PRESENT HISTORY

Height _____ Weight _____ Last physical Exam: _____

EMG Studies Yes _____ No _____ Date _____ Chest X-Ray? Yes _____ No _____ Date _____

Mammogram? Yes _____ No _____ Date _____ Could you be Pregnant? _____

Name and address of Doctor or Facility _____

Serious Illness (Please List) _____

MEDICATIONS you are now taking including blood thinners, aspirin, bufferin, birth control pills, diuretics, blood pressure or heart medications, tranquilizers, hormones, ibuprofen, etc.

MEDICATION ALLERGIES _____

PREOPERATIVE INFORMATION Have You Ever Had....? (Answer Yes or No)

Mental or Nervous Disease _____ Glaucoma _____ Cataracts _____

High Blood Pressure _____ Heart Disease _____ Diabetes _____

Lung Disease _____ Kidney Disease _____ Asthma _____

Keloids (thick scars) _____ Bruise/Bleed easily _____ Allergic to adhesive _____

Patient Signature(If patient minor, parent must sign)

Date