



Past Medical History

Information Source: Patient Spouse Parent
Select All That Apply Legal Guardian

Scheduled Procedure: _____

Date of Procedure: ____ / ____ / ____ mm/dd/yy

Best Number to Reach You: (____) _____ - _____ Ext: _____

Primary Language: English Spanish Other: _____
 Interpreter Needed? Yes No

Vision Difficulties? Yes No Comment: _____

Hearing Loss? Yes No Comment: _____

History of Surgery? Yes No
If Yes, Please List _____

Implanted Devices? Yes No Type: _____

Other Hospitalization? Yes No Comment: _____

Problems with Anesthesia? Yes No Comment: _____

Malignant Hyperthermia? Yes No

Family Problems with Anesthesia? Yes No Comment: _____

Respiratory Problems? Yes No Comment: _____
 Last Chest X-Ray Date: _____

Cardiac Problems? Yes No Comment: _____

Do You Have a Pacemaker? Yes No

Ever Had Chest Pain? Yes No Comment: _____

Heart Attack? Yes No Comment: _____

Date of Last EKG: ____ / ____ / ____ mm/dd/yy

Date of Last Stress Test: ____ / ____ / ____ mm/dd/yy

Cardiologist Name: _____

Cardiologist Number: (____) _____ - _____ Ext: _____

History of Blood Clots:	Yes	No	Comment: _____
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Neurological Problems?	Yes	No	Comment: _____
<hr/>			
Eyes/Ears/Nose/Throat Problems?	Yes	No	Comment: _____
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Gastrointestinal Problems?	Yes	No	Comment: _____
Have You Ever Had Hepatitis?	Yes	No	Type: _____
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Urinary Problems?	Yes	No	Comment: _____
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Reproductive Problems?	Yes	No	Comment: _____
<hr/>			
Last Menstrual Cycle?	_____		
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Birth Control Method:	_____		
<hr/>			
Previous Pregnancy?	Yes	No	Not Applicable
<hr/>			
Are You Pregnant Now?	Yes	No	Not Applicable
<hr/>			
Are You Breastfeeding?	Yes	No	Not Applicable
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Endocrine Problems? (Ex: Thyroid, Diabetes)	Yes	No	Comment: _____
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Musculoskeletal Problems?	Yes	No	Comment: _____
Assistive Device Utilized:	Cane	Roll-A-Bout	Walker
<i>Select All That Apply</i>	Crutches	Rolling Walker	Wheelchair
	Prosthesis	Not Applicable	
<hr/>			
Do You Have Chronic Pain?	Yes	No	
<hr/>			
Skin Problems?	Yes	No	Comment: _____
Tattoos?	Yes	No	
Piercings?	Yes	No	
<hr/>			
Autoimmune Problems?	Yes	No	Comment: _____
HIV Positive?	Yes	No	
Ever Had Cancer?	Yes	No	Comment: _____
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History of Multi Drug Resistance Organism? (MRSA, VRE, CDIFF)	Yes	No	Comment: _____
<hr/>			
Bleeding/Clotting Problems?	Yes	No	Comment: _____
Hematologist Name:	_____		
Hematologist Number:	() -		Ext: _____
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Ever had a transfusion?	Yes	No	

Blood Transfusion Reaction? Yes No Comment: _____

Psychosocial Problems? Yes No Comment: _____

Religious/Cultural Beliefs
Affecting Healthcare? _____

Tobacco Use or History Of? Yes No
Tabacco Type Used: Cigarettes Cigars Chew
Select All That Apply Other
Average Daily Usage: One or Two Three to Five Six+
Date Quit? / / mm/dd/yy Have Not Quit

Alcohol Use or History Of? Yes No
Alcohol Type Used: Wine Beer Liquor
Select All That Apply Other
Average Daily Drinks: One or Two Three to Five Six+

Substance Abuse? Yes No

Other Medical History or Comments: _____

Known Family Medical Problems: _____

Regular Exercise? Yes No
Exercise Type? (Ex: Aerobics, Running, etc) _____
Daily Amount of Exercise? _____
Shortness of Breath or Chest Pain? Yes No

Primary Care Physician Name: _____

Primary Care Physician Number: () - Ext: _____

Pediatric Only:
Delivery or Birth Complications? Yes No Comment: _____

Birth Defects? Yes No Comment: _____

Genetic Disorder? Yes No Comment: _____

Developmental/Learning Delays? Yes No Comment: _____

Exposure to Smoke? Yes No