PATIENT MEDICAL INFORMATION

The Following information is needed by your Physician to provide the best type of care for you.

Patient Name ______________________________ Birth Date _____/_____/_______ Age ______________

Daytime Phone Number (______)__________-__________ Alternate Number (______)_______-__________

Emergency Contact Person with different phone number **Name** ____________________________

Phone (______)________-__________

Does the Patient live in a **Nursing Facility**? If so, which Facility? **Name** ____________________________

Phone (______)________-__________

Primary Physician Name ______________ Phone ______________ Last Seen ____________________

Cardiologist Name ______________ Phone ______________ Last Seen ____________________

Pulmonologist / Neurologist ______________________________ Phone ____________________

Pharmacy Name ____ Phone ____________________

Patient Height __________ **Weight** __________ Any body piercings? (Location) ______________

Allergies / Sensitivities Reactions **Latex Allergy?** Yes / No

Reaction ______________

Current Medications including vitamins, herbal supplements, over-the-counter medications, etc.
Please add dosage and frequency.

Are you taking aspirin or blood thinners? Yes / No Last date taken ____________________

Are you taking any diet/appetite suppressants medications? Yes / No Last date taken ______________

SOCIAL HISTORY

Smoke No / Yes ______ packs per day for______years I quit______years ago

Drink No / Yes How much? ________________________

Illegal or Prescription Drug Abuse No / Yes Which drug? ______________________________

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Patient Name ____________________________

MEDICAL HISTORY Do you have or have you had: (If you circle "Yes", please explain)

Patient

Yes No **Problems with Anesthesia?** ____________________
Yes No TMJ/difficult IV stick/slow to awaken from anesthesia?
Yes No Is it difficult for you to walk up 2 flights of steps without feeling short of breath?
Yes No Is it difficult for you to lie down flat for 30 minutes without feeling short of breath?
Yes No **Cardiac Disease?** heart attack/heart murmur/heart valve/CABG/stent/pacemaker A-fib/palpitations ____________________
Pacemaker: Date ____________ CABG: Date ____________
Yes No Cardiac Stents: Date ____________ Valve Replacement: Date ____________
Yes No Chest pains/angina/congestive heart failure/swelling to lower extremities? ____________________
Yes No **High blood pressure?** ____________ Controlled on medication? ____________
Yes No **Diabetes?** ____________ Average am fasting blood sugar ____________
Yes No **Lung disease/COPD?** shortness of breath or chronic cough? ____________
Yes No Do you use **oxygen**/How often? ____________
Yes No Asthma/wheezing? Date of last attack: ____________
Yes No Sleep apnea? ______ Do you use CPAP? ____________
Yes No Do you have any broken facial bones (nose or jaw)? ____________
Yes No Do you have dentures/bridges/loose teeth/caps/crowns ____________
Yes No Do you have problems hearing? Wear a hearing aid? ____________
Yes No Do you have any surgical implants or prosthesis? ____________
Yes No Thyroid disease? ____________
Yes No Ulcer/hiatal hernia/reflux or heartburn? ____________
Yes No Liver disease/jaundice/cirrhosis/other? ____________
Yes No Infectious Disease: Hepatitis/HIV/TB/C-diff/MRSA ____________
Yes No **Stroke/TIA/paralysis?** ____________ **Date:** ____________
Yes No Seizures/epilepsy? Date of last seizure: ____________
Yes No Tremors/Parkinson's Disease? ____________
Yes No Arthritis/joint pain/chronic back pain? ____________
Yes No Bladder/Prostate problems? ____________
Yes No **Kidney disease/dialysis?** ____________ What days? ____________
Yes No Anemia/Blood Transfusion? When ____________
Yes No Sickle Cell disease or Trait? ____________
Yes No Are you or could you be pregnant? ____________
Yes No Have you had previous surgery? Including Eye surgery (please list) ____________ ____________________
Yes No Have you ever been diagnosed with HIV, AIDs, HEP B, C or A or any other type of infectious disease? ____________
Yes No Do you have other health concerns? ____________
Yes No **Have you been sick or in the hospital in the last 30 days?** ____________ ____________________

Pediatric Patients: (additional questions)

Yes No Born Full term? ____________
Yes No Did your child spend any time in the ICU when born? ____________
Yes No Meeting all developmental milestones for age? ____________
Yes No Has your child ever been evaluated by a cardiologist or pulmonologist for any reason? ____________________

PATIENT MEDICAL INFORMATION

Patient Name ____________________

FAMILY HISTORY

Has anyone in your immediate family been treated for the following (If yes, please indicate relationship)

Yes No Diabetes? ____________________
Yes No High Blood Pressure? ____________________
Yes No Heart Disease? ____________________
Yes No Stroke? ____________________
Yes No Cancer? ____________________ Type: ____________________

Yes No Glaucoma? ____________________
Yes No Macular Degeneration? ____________________
Yes No Retinal Detachment? ____________________
Yes No Blindness? ____________________

Please circle "Y" if you have had any of these conditions in the last few weeks.

Constitutional
Y N Fatigue
Y N Fever
Y N Night Sweats
Y N Weakness
Y N Weight Loss
Y N Weight Gain

Cardiovascular
Y N Arrhythmia
Y N Calf Pain
Y N Irregular Heartbeat
Y N Palpitations
Y N Chest pain
Y N Fluid Retention
Y N Leg Swelling

Metabolic/Endocrine
Y N Cold Intolerance
Y N Heat Intolerance
Y N Increased Thirst
Y N Increased Hunger
Y N Increased Urination
Y N Low Blood Sugar

Integumentary
Y N Abnormal Hair
Y N Dry Skin
Y N Hives
Y N Itching Skin
Y N Nail Changes
Y N Rash
Y N Skin Lesion

HEENT
Y N Exophthalmos
Y N Hoarseness
Y N Hearing Loss
Y N Sinus Problems
Y N Sore Throat
Y N Ringing in Ears
Y N Vertigo

Gastrointestinal
Y N Decreased Appetite
Y N Abdominal Pain
Y N Constipation
Y N Diarrhea
Y N Heartburn
Y N Nausea

Neurological
Y N Balance Disturbance
Y N Dizziness
Y N Focal Weakness
Y N Headache
Y N Memory Difficulty
Y N Numbness/Tingling

Musculoskeletal
Y N Back Pain
Y N Fracture
Y N Painful Joints
Y N Gait Disturbance
Y N Joint Swelling
Y N Muscle Weakness
Y N Muscle Cramping

Respiratory
Y N Asthma
Y N Cough
Y N Coughing Blood
Y N Difficulty Breathing
Y N Diff Breath / exertion
Y N Wheezing

Genitourinary
Y N Painful Urination
Y N Frequent Urination
Y N Urgency
Y N Trouble Urinating

Psychiatric
Y N Depression
Y N Emotional Changes
Y N Frequent Nightmares
Y N Hallucinations
Y N Nervousness
Y N Anxiety
Y N Insomnia

Hematologic/Immunologic
Y N Bleeding
Y N Bruising
Y N Tender Lymph Node
Y N Environmental Allergies
Y N Food Allergies
Y N Seasonal Allergies

Signature of Patient: X ____________________ Date: ____________

PATIENTS: DO NOT FILL OUT INFORMATION BELOW. THIS IS FOR PHYSICIANS USE ONLY

Other Findings: ____________________

Date updated with patient ____________ Tech/Nurse sig ____________________
Date updated with patient ____________ Tech/Nurse sig ____________________
Date updated with patient ____________ Tech/Nurse sig ____________________

HISTORY REVIEW

Reviewed By: ____________________ ,RN/LPN Date ________ Time: ______ am/pm
Reviewed By: ____________________ , MD - Surgeon/Anesthesiologist Date ________ Time: ______ am/pm
Reviewed By: ____________________ ,RN/LPN Date ________ Time: ______ am/pm
Reviewed By: ____________________ , MD - Surgeon/Anesthesiologist Date ________ Time: ______ am/pm