

Name _____ DOB _____ DATE _____

PAST MEDICAL, FAMILY, AND SOCIAL HISTORY

Past medical: Please check all that apply

A) Medical Conditions

- ____ Diabetes
- ____ High Blood Pressure
- ____ Heart Attack
- ____ Stroke
- ____ Pacemaker
- ____ Bleeding problems
- ____ Cancer of _____
- ____ Other _____
- _____
- _____

B) Diseases of: (please explain)

- ____ Heart(coronary artery disease, cardiomyopathy etc)_____
- ____ Lungs(asthma, emphysema etc)_____
- ____ Liver_____
- ____ Kidneys_____
- ____ Nervous System(seizures etc)_____
- ____ Immune System(AIDS etc)_____
- ____ Other _____
- _____
- _____

Do you require antibiotics for dental/medical procedures? Yes No

What drug? _____ Why? _____

C) Operations (please note approximate date and hospital performed)

D) Current medicines (including vitamins, supplements, aspirin, prescriptions and over the counter medications. Please note dosages and frequency. Use a separate sheet if necessary.)

E) Allergies (medicines, X-ray dye, iodine, shellfish, LATEX)

Social History:

____ Smoke now? _____ Packs/day _____ Years
____ Ex-smoker? _____ Packs/day _____ Years
____ Drink Alcohol? Quantity/week _____

Employment: Present _____

Past _____

Family History:

A) Do any of the medical conditions/diseases listed above run in your family? Yes No Explain:

B) Does any family member have trouble with anesthesia? Yes No

C) Any Children? Yes No Number: _____