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MEDICAL HISTORY

Date _____

Name _____ Date of Birth _____

Reason for today's visit _____

Height: _____ Weight: _____ Allergies: _____

Do you smoke? ❑ Yes ❑ No
Do you use alcohol? ❑ Yes ❑ No
Do you use illegal drugs? ❑ Yes ❑ No

Do you have children? ❑ Yes # _____ ❑ No

Primary Physician:_____
Phone number: _____

Last menstrual period: _____

Past Medical History and Hospitalizations	
Date	Reason

Previous Surgical Procedures	
Date	Procedure

List any previous problems with anesthesia : _____

Describe any problems with the following:

- ❑ Heart _____
- ❑ Circulation _____
- ❑ Blood pressure _____
- ❑ Bleeding _____
- ❑ Anemia _____
- ❑ Lungs _____
- ❑ Breathing _____
- ❑ Asthma _____
- ❑ Liver _____
- ❑ Kidneys _____
- ❑ Stomach _____
- ❑ Thyroid _____
- ❑ Diabetes _____
- ❑ Breasts _____
- ❑ Brain _____
- ❑ Stroke _____
- ❑ Nerves _____
- ❑ Eyes _____
- ❑ Dry eyes _____
- ❑ Psychiatric disorders _____
- ❑ Skin _____
- ❑ Arthritis _____
- ❑ Cancer _____
- ❑ Weight change _____
- ❑ Immune system _____
- ❑ Congenital disorders _____

List any serious medical problems of parents, siblings or children: