Last Name _____ First Name _____ Date _____

MEDICAL HISTORY FORM

GENERAL HEALTH (circle one) GOOD FAIR POOR Please explain:

_____

Date of most recent physical exam: _____ Chest X-ray: _____ EKG _____
Height: _____ Weight: _____ Number of term pregnancies: _____

PREVIOUS SURGERY: (Please list)
Operation Date Surgeon Facility

_____
_____
_____
_____

ARE YOU ***ALLERGIC*** TO ANY MEDICATIONS (circle one) **YES** **NO**
If yes, please list with reaction

_____

Please **LIST ALL MEDICATIONS** you are currently taking (including prescription and non prescription drugs, **aspirin**, hormones, vitamins, herbs, birth control, recreations) include dosage:

_____
_____
_____
_____

Do you have an Internal Electronic Device (IED) YES NO
If yes, Company/Manufacturer _____ Device _____

Have you ever been treated for any of the following? (circle all that apply)

CANCER (specify) _____ **HEART DISEASE/HIGH BLOOD PRESSURE**

ASTHMA/LUNG DISEASE **DIABETES** **SLEEP APNEA** **SEIZURES/STROKE**

CAD **CHF** **CARDIAC ARRHYTHMIA** **REFLUX** **RENAL INSUFFICIENCY**

SKIN CONDITIONS (eczema, psoriasis, sclerodermatitis)

VASCULAR/CIRCULATORY/BLOOD/BLEEDING DISORDERS

What is your DAILY consumption of the following: Coffee/Tea ____ Alcohol _____ Tobacco _____

Are you allergic/sensitive to any surgical materials (i.e. adhesive tape, suture, iodine prep, etc)

YES NO If yes, please list: _____

Are you currently pregnant YES NO Revised 4/4/2007