Patient Medical Information Sheet

Name: ______________________ Date: __________ Birthdate: __________

What problem brought you to see us today? ______________________

Please check box if you currently have or recently had….

☐ Fevers or chills	☐ Feeling like your heart is fluttering	☐ Blood in stool or tar-black stool	☐ Bone, joint, or back pain
☐ Unexplained weight loss	☐ Shortness of breath	☐ Difficulty swallowing	☐ Muscle weakness or paralysis
☐ Excessive fatigue	☐ Coughing	☐ Heartburn or acid reflux	☐ Numbness or tingling
☐ Sore throat	☐ Wheezing	☐ Burning with urination	☐ Seizures or fainting
☐ Sinus drainage	☐ Coughing up sputum or blood	☐ Blood or pus in urine	☐ Skin soares or rashes
☐ Change in vision	☐ Abdominal pain	☐ Urge to urinate comes quickly	☐ Anxiety or depression
☐ Changes in hearing/ringing	☐ Diarrhea or constipation	☐ Frequent urination	☐ Heat or cold intolerance
☐ Chest pains	☐ Change in bowel habits	☐ Leaking of urine	☐ Excessive thirst

List all current medications: (Prescription and over-the-counter) ______________________

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List all known medication allergies and the reaction it causes: ______________________

Past Medical History: (Please check yes or no)

☐ Yes ☐ No Hypertension (High Blood Pressure)

☐ Yes ☐ No Heart Disease (Murmurs, Rheumatic Fever)

☐ Yes ☐ No Lung Disease (Emphysema, Asthma, etc.)

☐ Yes ☐ No Colitis (Crohn's Disease, Diverticulitis)

☐ Yes ☐ No Liver Disease (Hepatitis, etc.)

☐ Yes ☐ No Kidney Disease

☐ Yes ☐ No Cancer: ______________

☐ Yes ☐ No Tuberculosis

☐ Yes ☐ No Bleeding Disorders (Clotting Problems)

☐ Yes ☐ No History of Blood Clots

☐ Yes ☐ No Anemia/Low Blood Count

☐ Yes ☐ No Stroke/TIA

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Artificial Joints

☐ Yes ☐ No Ulcers

☐ Yes ☐ No HIV/AIDS

Family History:

Have parent/sibling/grandparent ever had the following?

(Please explain **type** and **who** has the problem)

Cancer ______________

Heart Disease ______________

Hypertension ______________

Bleeding Disorders ______________

Diabetes ______________

Any other conditions that exist in your family

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____

Have you ever had any adverse reactions to general anesthesia? ☐ Yes ☐ No

If so, please explain: ______________

____

Do you have a pacemaker? ☐ Yes ☐ No

PLEASE EXPLAIN ANY OTHER PAST MEDICAL PROBLEMS ______________________

____

FOR MEDICAL USE ONLY

B/P: Pulse: O2: Temp: Weight: lbs.

Past Surgical History:

Please list all previous surgeries and approximate dates:

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☐ Yes ☐ No Do you or have you ever smoked (pipes, cigars, cigarettes)?

If yes, how much per day? ______________________

☐ Yes ☐ No Do you drink alcoholic beverages? If yes, how much per week?___________________________

☐ Yes ☐ No Do you use illegal drugs? If yes, please explain____

How many pregnancies have you had? Live Births____ Miscarriages____ Abortions____