Patient Medical History

Patient Name	**Date of Birth**
Primary Care Provider Dr:._____ **Ph:**_____	**Cardiologist/Specialist Dr.:**_____ **Ph:** _____
Diagnosis: _____ **Surgical Procedure:**_____	**Surgeon:** _____ **Ph:**_____
METS Score (nurses use only): Wheelchair bound? Bedridden?	Height: Weight:

	YES	NO		YES	NO
Do you have or are you being treated for high blood pressure? *If yes, how many years?*_____	☐	☐	Have you ever had a heart valve replacement or repair?	☐	☐
Do you have chest pain with walking/normal activity? With exercise?	☐	☐	Do you have a pacemaker or defibrillator?	☐	☐
Have you ever had a coronary bypass or angioplasty?	☐	☐	Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm?	☐	☐
Have you ever had a heart attack? *If yes, how many?:* _____*When?:* _____	☐	☐	Have you ever been told you have peripheral vascular disease?	☐	☐
Do you have a heart stent? *If yes, how many?:* _____ *When?:* _____	☐	☐	Have you ever had a stress test? *If yes, where?:* _____ *When?:* _____	☐	☐
Do you have a weak or failing heart (congestive heart failure, CHF)?	☐	☐	Have you ever had a cardiac echo test? *If yes, where?:* _____ *When?:* _____	☐	☐
Do you have an irregular heartbeat or heart rhythm?	☐	☐	Have you ever had a heart catheterization? *If yes, where?:* _____ *When?:* _____	☐	☐
Do you have a heart murmur or mitral valve prolapse?	☐	☐			
Do you take daily medication for asthma?	☐	☐	Do you have difficulty breathing (do you wheeze)?	☐	☐
Do you have a history of chronic bronchitis or emphysema (COPD)?	☐	☐	Do you use supplemental oxygen?	☐	☐
Do you smoke? *If yes, how many packs / day:____ How may years have you been a smoker?:* _____	☐	☐	Do you have a history of sleep apnea? CPAP?	☐	☐
Have you had any recent colds, fever or flu symptoms?	☐	☐	Have you ever been witnessed to stop breathing while asleep?	☐	☐
Do you have diabetes? *If yes, for how many years?:*_____*Complications?:*_____	☐	☐	Do you take insulin?	☐	☐
Do you have kidney problems (other than kidney stones)?	☐	☐	Have you ever had Hepatitis A / B / C / D? (circle)	☐	☐
Do you have liver problems?	☐	☐			
Do you drink alcohol every day? *If yes, how many drinks/day:*_____	☐	☐	Do you use recreational drugs? *If yes, specify*_____	☐	☐

Please Turn Over To Continue

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	YES	NO		YES	NO
Do you have a history of anemia?	☐	☐	Do you have a history of sickle cell disease or trait?	☐	☐
Do you take any blood thinners (e.g. Coumadin)?	☐	☐	Do you have a history of cancer?	☐	☐
Do you take Aspirin or Ibuprofen regularly?	☐	☐	Are you on Chemo Therapy?	☐	☐
Do you have seizures or take anti-seizure medications?	☐	☐	Do you have neuromuscular disease (including Parkinson's, ALS etc)?	☐	☐
Have you ever had a stroke(CVA), mini stroke(TIA) or brain attack? *If yes, when?:* _____	☐	☐	Do you have a brain tumor, brain aneurysm or other vascular lesion of the brain?	☐	☐
Have you been told that it is difficult to place a breathing tube in your airway (intubate)?	☐	☐	Do you have a history of severe reaction to anesthesia?	☐	☐
Do you or a family member have a history of high fever after anesthesia (malignant hyperthermia)?	☐	☐	Do you suffer from chronic pain?	☐	☐
Do you have a history of severe nausea and vomiting after anesthesia?	☐	☐	Is there a possibility you could be pregnant? *LMP:*_____	☐	☐
Do you have an autoimmune disease (such as Rheumatoid Arthritis, Sarcoidosis or Lupus)?	☐	☐	Do you have any other medical problems that we have not asked you about? *If yes, specify:*_____	☐	☐
OFFICE USE: EKG results good for 6 months. Chemistry lab results good for 3 months					

Please list the medications you currently take and the dose.

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Conditions

Check conditions you currently have or have had in the past year.

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Cancer
- ☐ HIV Positive
- ☐ Thyroid Problems
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Have you ever had your colon examined with a scope or X-ray?

If yes, when _____

Have you ever had your stomach examined with a scope or X-ray?

If yes, when _____

PAST MEDICAL HISTORY

_____

_____

_____

_____

Allergies

List any allergies to medications, food, substances or reactions to anesthesia

_____

_____

_____

Prior Surgical Procedures

Type of Surgery	Date of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

Is there a family history of:

- ☐ Cancer
- ☐ Diabetes
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Other_____

_____