MEDICAL HISTORY

Patient's Name: _____ Date: _____

Please list all **allergies**: _____

List all **medications** you are **currently** taking: _____

_____

_____

_____

List all current medical problems: _____

_____

List all surgeries from birth to present: _____

List any broken bones from birth to present: _____

List any immediate family member with a significant medical problem, explain: _____

_____

Do you or any immediate family members have difficulty undergoing **anesthesia**? Yes / No If yes, please list: _____

_____

Smoking Status: (circle) **Non-Smoker / Former Smoker / Current Smoker**

Do you have a history of **drug and/or alcohol abuse**? _____

If you have any of the following symptoms, please mark the corresponding box and explain below if necessary:

☐ **chills**	☐ **sore throat**	☐ **venereal disease**	☐ **varicose veins**
☐ **fever**	☐ **cough**	☐ **kidney disease**	☐ **leg cramps**
☐ **night sweats**	☐ **tuberculosis**	☐ **difficult urination**	☐ **joint pain**
☐ **weight loss / gain**	☐ **wheezing / asthma**	☐ **hernia**	☐ **joint swelling**
☐ **cancer / tumors**	☐ **high blood pressure**	☐ **diabetes**	☐ **gout**
☐ **rash**	☐ **leg swelling**	☐ **abnormal periods**	☐ **arthritis**
☐ **growths**	☐ **heart attack / trouble / murmur**	☐ **thyroid disease**	☐ **numbness**
☐ **skin cancer**	☐ **ulcers**	☐ **HIV/AIDS**	☐ **tingling**
☐ **hives**	☐ **heartburn**	☐ **hepatitis**	☐ **weakness**
☐ **blurred vision**	☐ **constipation**	☐ **anemia**	☐ **depression**
☐ **headache**	☐ **diarrhea**	☐ **bruise or bleed easily**	☐ **tremor**
☐ **hearing loss**	☐ **liver disease**	☐ **blood clots**	

Explanation of **positive** responses, if necessary: _____

_____

____ Check here if all of the above are **negative**

I declare that the above is correct to the best of my knowledge: _____

patient/parent/guardian signature