Patient History Form - Fi

Name		Date
Height	Weight	Date of Birth:
List all allergies		
List all Medications that you are taking		
List all the surgeries or medical procedures you have had in past:		
Have you had any problems with anesthesia in past? If yes, please tell what happened.		
Last menstrual cycle:		Smoke Cigarettes Y N
Alcohol use Y N	If yes, how often:	Drug use Y N

Past Medical History: check all that apply

- High blood pressure: _____
- Heart Disease *Have you ever been seen by a cardiologist? Y N
- Asthma or any lung/breathing conditions
- Sleep apnea Y N Do you snore? Y N
- Diabetes (Type 1 or Type 2) Y N Do you use insulin? Y N
- Kidney Disease: _____
- Cancer Type: _____
- Acid reflux and/or stomach ulcer: _____
- Thyroid Disease: _____
- Arthritis and/or Back problems: _____
- Aids/HIV: _____
- Blood clotting conditions: _____
- Seizures or Stoke: _____
- Glasses or contacts: _____

My telephone number:	Emergency contact name/number:
Office Use Only	
Procedure date	Arrival time
Care giver name	
Labs	BP
Anesthesia	HR