PAST MEDICAL HISTORY

Patient Name_____Date_____

Please Circle Y (YES) or N (NO) if you have had the following medical conditions now or in the past:

Heart:
Y N Coronary Disease
Y N MI/Heart Attack
Y N Congestive Heart Failure
Y N Atrial Fibrillation
Y N Angina
Y N Valve Disorder
Y N Pace Maker
Y N High Cholesterol
Y N Hypertension

Neurological:
Y N Stroke
Y N TIA
Y N Seizures
Y N Bell's Palsy
Y N Sleep Apnea

Blood Clots
Y N Lung
Y N Legs

Kidney:
Y N Infection
Y N Failure
Y N Stones

Arthritis:
Y N Osteoarthritis
Y N Rheumatoid
Y N Psoriatic

Diabetes:
Y N Type I
Y N Type II

GI:
Y N Ulcers
Y N Pancreatitis
Y N Diverticulitis

Psychological:
Y N Anxiety
Y N Depression
Y N Bipolar
Y N OCD
Y N ADHD

Chronic Pain:
Y N Back
Y N Fibromyalgia
Y N Neuropathy

Other: _____

PRIOR SURGERIES & DATES:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you had any problems with Anesthesia? ____NO ___ YES (Please Explain)

_____

Did you have any problems with Abnormal Bleeding? ____NO ____YES (Please Explain)

_____

NURSES' NOTES:

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