Name: ____________________________

Patient Medical History (Do not include family history)

Do you have or have you had any of the following?

	Yes	No	If Yes, explain:
Dentures – Partials – Broken Teeth – Loose Teeth			
Emphysema – Asthma – Tuberculosis – Short of Breath			
Bronchitis – Pneumonia – Sinusitis – RSV			
Sleep Apnea – Supplemental Oxygen requirement			
Thyroid problems – Diabetes – Hypoglycemia			
Kidney problems – Bladder problems – Prostate Problems			
Congestive Heart Failure – History of Heart Attack – Chest Pain			
Irregular Heartbeat – Pacemaker – Heart Disease			
High Blood Pressure – High Cholesterol			
Bleeding Problems – Circulatory Problems – Blood Clots Varicose Veins			
Hepatitis – Liver Disease – Jaundice			
Acid Reflux (GERD) – Ulcer – Hernia			
Bowel Disorders – Esophageal Disorders			
AIDS/HIV – MRSA			
Seizures – Fainting – Stroke – Mini Stroke (TIA)			
Osteo Arthritis – Rheumatoid Arthritis – Physical Limitations			
Depression – Anxiety – Bipolar - Mental Disorders			
Family history of Malignant Hyperthermia			
Use special equipment (i.e. crutches, walker, CPAP, hearing aids, etc…)			
Chronic Pain – Neuropathy – Numbness/Tingling			
For Children: Premature birth - Overnight Hospital stays			
Chronic Strep Throat – Chronic Tonsillitis – Chronic Ear Infections			

List any diagnoses that are not listed on previous page:

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Surgical History

Surgery	Date	Any Complications?

Daily Medications List

(including all prescription medications, all over-the-counter medications, vitamins, supplements, and herbs)

Medications, Vitamins, Supplements, Herbs	Dose taken and how often:	Day of last dose taken:

Reviewed and verified by: ____

Staff signature Date/Time