



### Medical and Surgical History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ Food Allergies: \_\_\_\_\_

Latex Allergy: \_\_\_\_\_ Yes \_\_\_\_\_ No Allergy to IV Contrast Dye? \_\_\_\_\_ Yes \_\_\_\_\_ No

Patient's Medical History: Is the patient currently experiencing, or has he/she ever experienced, any of the following?

Yes	No	
_____	_____	Neurological problems, such as dizziness, loss of balance or coordination, numbness, tingling, headaches, vision changes, seizures
_____	_____	Lung problems, such as shortness of breath, wheezing, cough, asthma, TB
_____	_____	Heart problems, chest pain, high blood pressure, circulatory problems
_____	_____	Bleeding or clotting disorders
_____	_____	Musculoskeletal problems, arthritis or lupus
_____	_____	Stomach/bowel problems, heartburn, vomiting, diarrhea, constipation
_____	_____	Hepatitis or liver problems
_____	_____	Endocrine problems, diabetes or thyroid problems
_____	_____	Kidney or bladder problems
_____	_____	Pain
_____	_____	Physical limitations, learning disabilities, or delayed growth
_____	_____	Autoimmune Disorder
_____	_____	Skin Disorder
_____	_____	Cancer
_____	_____	Anxiety, mental health-related history
_____	_____	Implantable devices (pacemaker, pumps)

List other health issues: \_\_\_\_\_

Family Medical History: (excessive bleeding? reaction to anesthesia? other?) \_\_\_\_\_

Patients Surgical History: (List date and what procedure was done) \_\_\_\_\_

Adults Only:

Yes	No	
_____	_____	Do you smoke?
_____	_____	Do you drink alcohol?
_____	_____	Do you use recreational drugs?

Pediatrics Only:

Yes	No	
_____	_____	Immunizations up to date?
_____	_____	Exposure to communicable diseases?
_____	_____	In Daycare?
_____	_____	Smoke Exposure?

Medications and dosage: (Include over-the-counter and herbs/vitamins) \_\_\_\_\_

The above information represents a true and complete history:

Signature \_\_\_\_\_

Date Signed: \_\_\_\_\_