Past Medical History Questionnaire

Patient Label

Name:_____________________ Surgeon:_____________________

Escort:_____________________ Procedure:_____________________

Height:__________ Weight: __________ Pain score today:________ out of 10

Allergies:_____________________ Date of last Center visit: ____/____/____ ☐N/A

Are you currently being treated by a physician on a regular basis?_____________________

What diagnosis?_____________________

Outpatient:__________ Inpatient:__________ How often:__________ Last treatment:__________

Prescriptions refilled on a regular basis:_____________________

Any Changes in Medical History since your last visit?

☐ **YES (please complete form)** ☐ **NO** **Patient signature**_____________________

Please list all the medications you are taking (over the counter included) and the last time of day you took them: ☐ **see attached med list**

Medication	Last dose	Medication	Last dose	Medication	Last dose

Please list all previous surgeries and hospitalizations:

Date	Medical Condition/Surgery	Date	Medical Condition/Surgery

Please check whether you have any of these conditions:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		Irregular Heartbeat/ Arrhythmias			Alcohol or recreational drug use			Problems w/Anesthesia?
		Chest Pain			Diabetes			Family history w/anes.
		High blood pressure			Hyperthyroidism			
		Low blood pressure			Hypothyroidism			Stroke
		Heart Attack			Other Thyroid prob			Seizures
		Heart murmur			Gastric reflux			Parkinson's Disease
		Heart catheterization			Ulcers			Other neuro problems
		Valve replacement			Hiatal hernia			MRSA/Staph infection
		Other Heart problems			Other GI problems			TB
		COPD						HIV or AIDS
		Asthma / Allergies			Depression / BiPolar			Hepatitis
		Chronic cough			Psychiatric Disorders			Other infectious prob
		Sleep Apnea			Anemia			
		Shortness of breath			Excessive bleeding			
		Other respiratory prob			Other bleeding disorders			Urinary or Kidney Disorders
		Smoker packs per day ____x____years			Any other conditions??			Special needs: wheelchair, cane, etc...

Completed by: Reviewed by:

_____________________ __________ _____________________ __________

Patient signature Date Physician signature Date