Name: ______________________________________ DOB: _______________ Weight: _________ Height: _________

PREVIOUS SURGERIES: Date	CURRENT MEDICATIONS
	Medication Name Dosage Frequency
MAJOR MEDICAL ILLNESSES	
	Do you take any of the following (please circle)
	Coumadin (Wafarin), Plavix, Xarelto, Aspirin
	Ibuprofen, Advil, Motrin, Aleve, Naprosyn
	How often?
Have you or a family member had issues with anesthesia?	Which provider manages your Coumadin?
Yes No	
	Non prescription drugs & supplements
ALLERGIES TO MEDICATIONS Reaction	
	HABITS
	Alcohol Use: Yes No How often?
	Smoking Status: Never Former Current
	If current; cigarettes/pack per day?
OTHER ALLERGIES:	If former; when did you quit? Month: Year:
Latex Sulphites	How many years have you smoked for?
Iodine Eggs	Smokeless Tobacco Use: Never Former Current
Tape Seafoods	If current; how often?
Soy products Other foods	If former; when did you quit? Month/Year:
Other	Recreational drugs: Yes No
	If yes, please specify:

FAMILY HISTORY

MG-Maternal Grandparent; **PG**-Paternal Grandparent; **M**-Mother; **F**-Father; **B**-Brother; **S**-Sister; **C**-Child

Using the key above, please circle and indicate if any blood relatives have been diagosed with the following:

Heart problem	**Yes No** __________	Blood Disorders **Yes No** _______________	Cancer	**Yes No** ___________
High blood pressure	**Yes No** __________	Problems w/ anesthesia **Yes No** _______	Diabetes	**Yes No** ___________

Patient Signature: ____ **Date:** __________________

------------------------------ ***Reviewed and Updated*** ------------------------------

Patient Signature: ________________________________ Date: ______________________ Staff/RN: ______________________

FOR OFFICE USE ONLY

Chief Complaint: ____

History of Present Illness: ____

Clinical Staff Review: ________________________

Initial/Date