Name: Date:

DOB:

PATIENT HISTORY FORM

Are you: ☐ Right handed ☐ Left handed ☐ Ambidextrous Height: _____ Weight: _____

Medical History: Do you currently or have had any of the following? ☐ **NONE**

☐ seizures	☐ stroke	☐ diabetes	☐ hypothyroidism
☐ congestive heart failure	☐ coronary artery disease	☐ heart attack	☐ heart murmur
☐ high blood pressure	☐ high cholesterol	☐ irregular heart beat	☐ pacemaker
☐ asthma	☐ COPD	☐ sleep apnea / CPAP	☐ reflux / heartburn
☐ stomach ulcers	☐ colitis	☐ Crohn's disease	☐ hepatitis / liver disease
☐ kidney disease _____	☐ arthritis	☐ chronic pain	☐ gout
☐ fibromyalgia	☐ osteomyelitis	☐ osteoporosis	☐ anemia
☐ bleeding disorder	☐ blood clots	☐ HIV / AIDS	☐ MRSA / VRE
☐ poor circulation	☐ cancer _____	☐ depression	☐ drug / alcohol problem
☐ psychiatric illness	☐ pregnancy (current)	☐ other / details _____	

Surgical History: ☐ **NONE.** Circle all that apply:

☐ Eyes / ENT: cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other _____

☐ Heart: bypass, valve replacement, stent, other _____

☐ Lung: resection, other _____

☐ Gastrointestinal: appendix, gall bladder, hernia, other _____

☐ Gynecologic: C-section, hysterectomy, tubal ligation, other _____

☐ Urologic: prostate, bladder, vasectomy, other _____

☐ Orthopaedic: joint replacement, arthroscopy, fracture surgery, spine, other _____

☐ Vascular: carotid, aneurysm, bypass, other _____

☐ Neurosurgical: aneurysm, tumor, craniotomy, other _____

☐ Cancer: skin, breast, thyroid, other _____

☐ Other: _____

Anesthesia Complications: ☐ **NONE.** If yes, explain: _____

Medications: ☐ **NONE** ☐ additional sheet attached ☐ Are you taking any blood thinners? ☐ Have you taken chronic steroids?

Medication (include over the counter medicines)	**Dose and Frequency**
1.	
2.	
3.	
4.	
5.	

Medical Allergies: ☐ **NONE** ☐ penicillin ☐ sulfa ☐ latex ☐ metals ☐ tape ☐ iodine (IV contrast) ☐ shellfish ☐ poultry products ☐ anti-inflammatories ☐ other _____

Social History:

Alcohol Use: ☐ none ☐ occasional ☐ weekly ☐ daily

Tobacco Use: ☐ none ☐ previous When did you quit? _____ ☐ current packs / day: _____

When did you start? _____

Recreational Drug Use: ☐ none ☐ previous ☐ current drug _____ Last used? _____

Family History (mother / father / siblings): ☐ **NONE OF THE BELOW**

☐ anesthesia complications _____	☐ heart disease _____
☐ arthritis _____	☐ high blood pressure _____
☐ bleeding disorder/blood clots _____	☐ kidney disease _____
☐ cancer _____	☐ thyroid disease _____
☐ diabetes _____	☐ other _____

Patient or Responsible Party Signature: _____ Date: _____

Provider Signature: _____ Date: _____