Medical History Form

Height_______ Weight________

Patients Name / Surgery Date and Surgeon:

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1.Have you ever had surgery before? If so, have you had problems with anesthesia in the past , such as nausea and vomiting ? Has anyone in your family had trouble with an anesthetic?___________________________

2.Do you have breathing problems such as sleep apnea ,COPD, emphysema, asthma, or a trach ? _____________________Do you use an inhaler or CPAP machine?___________________________________

3.Have you ever had a heart attack, high blood pressure, stroke, dizzy spells, or fainting?____

4. For female patients: have you had a hysterectomy or tubal ? Yes or No

5. List of medications and dosages: pt instructed to bring list with them

a.______________________________ d.___________________________

b.______________________________ e.___________________________

c.______________________________ f.___________________________

6. List ALL Drug allergies:____

7. Do you have acid reflux or a hiatal hernia?____________________________

8. Have you spoken with our office staff concerning your insurance info? Yes No

Comments :____

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