PAST MEDICAL AND SOCIAL HISTORY

Name_____ Today's Date: _____/_____/_____

Birth Date:_____ / _____ / _____

PLEASE CHECK THE BOXES WHERE APPROPRIATE TO YOUR MEDICAL CONDITIONS

- ❑ NONE Reported
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis , Osteo
- ❑ Arthritis, Rheumatoid
- ❑ Asthma
- ❑ Bipolar Disorder
- ❑ Bleeding Disorder
- ❑ Blood Transfusion
- ❑ Blood Disorder , Other
- ❑ Cancer
- ❑ Cardiac Arrhythmia
- ❑ Cognative Impairments
- ❑ Depression
- ❑ Diabetes, Insulin Dependent
- ❑ Diabetes, Non Insulin Dependent
- ❑ Ear Disease, Other
- ❑ Ear Infections
- ❑ Ear Tubes
- ❑ Eating Disorder
- ❑ Emphysema/COPD
- ❑ Endocrine Disorder, Other
- ❑ Eye Disease
- ❑ Fibromyalgia
- ❑ Gastroesophageal Reflux Disease
- ❑ Glaucoma
- ❑ Goiter
- ❑ HIV
- ❑ Head Trauma
- ❑ Hearing Aids
- ❑ Hearing Loss
- ❑ Heart Attack
- ❑ Heart Disease, Other
- ❑ Heart Valve Problem
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hyperthyroidism (Over Active)
- ❑ Hypothyroidism (Under Active)
- ❑ Kidney Disease, other
- ❑ Kidney Disease, On Dialysis
- ❑ Kidney Stone
- ❑ Liver Disease
- ❑ Lung Disease, Other
- ❑ Lupus
- ❑ Meniere's Disease/Labyrinthitis
- ❑ Migraine Headaches
- ❑ Mitral Valve Prolapse
- ❑ Multiple Sclerosis
- ❑ Musculoskeletal Disorder, Other
- ❑ Nasal; Fracture
- ❑ Neurological Disease, Other
- ❑ Noise Exposure
- ❑ Osteoporosis
- ❑ Parathyroid Problem (High Calcium)
- ❑ Parkinson's Disease
- ❑ Seizure Disorder
- ❑ Sexually Transmitted Disease
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Substance Abuse
- ❑ Thyroid Disease
- ❑ Thyroid Nodule
- ❑ Tumors, Benign

❑ Other Medical Conditions:_____

_____

❑ Cancer Location:_____

Date Diagnosed:_____ ❑ Treatment ❑ Radiation ❑ Surgery ❑ Chemotherapy

Additional Cancer Related Information:_____

_____

CHILDHOOD MEDICAL HISTORY

- ❑ NONE Reported
- ❑ ADHD
- ❑ Apgar Score Less than 6
- ❑ Asthma
- ❑ Birth Marks
- ❑ Birth Weight Less than 3.3
- ❑ Born Premature
- ❑ Cerebral Palsy
- ❑ Chickenpox
- ❑ Childhood Hearing Loss
- ❑ Developmental Delays
- ❑ Diabetes
- ❑ Ear Infection
- ❑ Head Injury
- ❑ Measles
- ❑ Meningitis
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Pneumonia
- ❑ Recurrent Croup
- ❑ Required Intubation at Birth
- ❑ Rheumatic Fever
- ❑ Rubella
- ❑ Speech Delay
- ❑ Strep Throat

❑ Other Childhood Medical History Information :_____

_____

PREVIOUS HISTORY OF PROBLEMS WITH ANESTHESIA

- ❑ NONE Reported
- ❑ Cardiac Arrhythmia
- ❑ Cardiovascular Collapse
- ❑ Difficult Intubation
- ❑ Hyperthermia, Malignant
- ❑ Nausea
- ❑ Took a long time to wake up
- ❑ Vocal Cord Injury
- ❑ Vomiting

Turn page over to complete form on other side. ⟶

PAST MEDICAL AND SOCIAL HISTORY *continued*

MEDICATIONS

Allergies to Medications? ❑ Yes ❑ No

If "Yes", please list & Describe Reaction:_____

_____

Currently Taking Medication: ❑ Yes ❑ No If "Yes" , Please list:

1	4
2	5
3	6

PREVIOUS SURGERIES

❑ NONE Reported
❑ Angioplasty
❑ Carotid Endarterectomy
❑ Coronary Artery Bypass Graft (CABG)
❑ Coronary Artery Stenting
❑ Gastric Bypass
❑ Cardiac Defibrillator
❑ Pacemaker
❑ Tonsillectomy
❑ Other_____

SOCIAL HISTORY

SMOKING HISTORY
❑ NONE reported
❑ Current Every Day Smoker
❑ Current Some Day Smoker
❑ Former Smoker
❑ Smoke 1 1/2 ppd
❑ Smoke 1 ppd
❑ Smoke 1/2 ppd
❑ Smoke 2 ppd

ALCOHOL HISTORY
❑ None reported
❑ Current Alcohol Use Occasionally
❑ Current Alcohol Use Rarely
❑ Current Excessive Alcohol Use
❑ Former Alcohol Abuse
❑ Former Alcohol Use Occasionally
❑ Never Used Alcohol

DRUG HISTORY
❑ Denies Drug Use
❑ Current Drug User
❑ Current Illegal IV Drug User
❑ Current Illegal Inhalation Drug Use
❑ Current Prescription Drug Addiction
❑ Former Illegal IV Drug User
❑ Former Illegal Inhalation Drug Use
❑ Former Prescription Drug Addiction

EXERCISE HISTORY: ❑ Currently None ❑ Currently Daily ❑ Currently Several Times a Week ❑ Currently Sporadic

OCCUPATION: _____

FAMILY HISTORY M = Mother F = Father S = Sister B = Brother O = Other

	M	F	S	B	O		M	F	S	B	O		M	F	S	B	O
NONE reported	❑	❑	❑	❑	❑	Hearing Loss	❑	❑	❑	❑	❑	Noncontributory	❑	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑	❑	Heart Disease	❑	❑	❑	❑	❑	Parathyroid Disease (high calcium)	❑	❑	❑	❑	❑
Anesthesia Complication	❑	❑	❑	❑	❑	Hypertension	❑	❑	❑	❑	❑	Problems with Anesthesia	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	Hyperthyroidism (over Active)	❑	❑	❑	❑	❑	Seizure Disorder	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	Hypothyroidism (under Active)	❑	❑	❑	❑	❑	Thyroid Cancer	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	Kidney Disease	❑	❑	❑	❑	❑	Thyroid Disease	❑	❑	❑	❑	❑
Emphysema/Asthma/COPD	❑	❑	❑	❑	❑	Kidney Stones	❑	❑	❑	❑	❑	Tuberculosis	❑	❑	❑	❑	❑
Headache, Chronic	❑	❑	❑	❑	❑	Mental Illness	❑	❑	❑	❑	❑	Unknown	❑	❑	❑	❑	❑

REVIEW OF SYSTEMS

IN THE PAST MONTH, HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING :

CONSTITUTIONAL SYSTEMS
❑ Chills
❑ Fatigue
❑ Fever
❑ Daytime Sleepiness
❑ Sweats
❑ Weight Gain
❑ Weight Loss

EYES
❑ Diplopia (Double Vision)
❑ Irritation
❑ itching

SKIN
❑ Skin Dryness
❑ MRSA

EARS
❑ Hearing Loss
❑ Ear Pain
❑ Ringing

NOSE
❑ Bloody Nose
❑ Obstruction
❑ Post Nasal Drip
❑ Sense of Smell, Decreased
❑ Sinus Pressure
❑ Sneezing

CARDIAC
❑ Chest Pain
❑ Tachycardia (Rapid Heartbeat)

RESPIRATORY
❑ Cough
❑ Shortness of Breath
❑ Snoring
❑ Wheezing

GASTROINTESTINAL
❑ Constipation
❑ Diarrhea
❑ Heartburn
❑ Indigestion

MUSCULAR
❑ Arthritis
❑ Muscle Aches

ENDOCRINE
❑ Fatigue
❑ Hot Flashes
❑ Intolerance to Cold

HEMATOLOGIC
❑ Bleeding, easy
❑ Bruising, easy

LYMPHATIC
❑ Enlarged Lymph Nodes
❑ Neck Mass

ALLERGY/IMMUNOLOGIC
❑ Allergies, Seasonal
❑ Sneezing
❑ Tongue Swelling

NEUROLOGICAL
❑ Dizziness
❑ Headache
❑ Tremor

THROAT
❑ Altered Taste
❑ Halitosis (Bad Breath)
❑ Hemoptysis (Blood)
❑ Swallowing Difficulty
❑ Throat, Sore
❑ Voice Change

This form was completed by: _____ _____

Signature (Required) Printed Name