The questions below are about your medical history NOT your family
Check the box marked YES if you have now or ever had any of the following

	Yes	NO	*If you answer YES to any question add Information here*
Heart problems			
High Blood Pressure			
Seeing a Cardiologist			Dr. Name:
Short of breath			
Asthma			
Emphysema			
Sleep apnea			
CPAP Use			
Smoke			Number of cigarettes per day How Long?
Chew tobacco			How long?
Hiatal Hernia			
Reflux or GERD			
Ulcers			
Frequent Heartburn			
Diabetes			Type 1 or Type 2? Dr. Name:
Hepatitis			Hep. A B C Now or resolved (circle)
Liver problems			
Stroke			
Seizures			Cause date of last seizure
Migraines			Date of last migraine
Chronic Pain Issues			Describe:
Taking Medicine for Chronic Pain			
Arthritis			Rheumatoid? Osteoarthritis?
Drink Alcohol			weekly average amount:
Recovering alcoholic			When did you quit?
Use Cocaine			Use weekly / daily? Date of last use
Use Marijuana			Use weekly / daily? Date of last use
Cancer			Location of cancer
Chemotherapy or radiation			date of therapy What year?
Kidney disease			
kidney failure			Are you on Dialysis? Yes No (circle)
kidney stones			
Loose Teeth			
Dentures, Bridges or flippers			
Hearing problems			
Hearing aid(s)			Right ear Left ear Both ears (circle)
Glaucoma			
Thyroid problems			

Last Menstrual Period Month/Year

List any other medical conditions you have that are not listed here.
(For example, bleeding or bruising issues,anemia, HIV, AIDS)

What surgeries have you had : (dates are NOT needed)

Any Problems with Anesthesia None Nausea Vomiting (circle) Other:

Give this to the Nurse in the Pre-op clinic