

MEDICAL HISTORY UPDATE

Name of patient _____ Age _____ Wt _____ Ht _____ Sex _____ DOB _____

Occupation _____ Ethnic/Racial Background _____

Are you presently in good health? Yes No

Past serious illnesses?
 If yes, please explain _____

Are you being treated for any illness?
 If yes, please explain _____

List all medications which you are taking _____

Allergies to medications?
 If yes, please list _____

Date of last physical exam _____

Is there any chance you are pregnant?
 If yes, please explain _____

Have you ever had a blood transfusion?
 List all operations in the past _____

Any reaction to anesthesia?

Do you use tobacco products?
 If yes, please list how much and for how long _____

Do you drink alcoholic beverages?
 If yes, please list how much and how long _____

Have you seen other doctors for the problem which brings you here today?
 If yes, please list _____

DO YOU HAVE A PAST HISTORY OF

	Yes	No		Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Street drugs	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>
Lung problems	<input type="checkbox"/>	<input type="checkbox"/>	Bad scarring	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Communicable diseases	<input type="checkbox"/>	<input type="checkbox"/>
Mouth-breathing	<input type="checkbox"/>	<input type="checkbox"/>	Serious injuries	<input type="checkbox"/>	<input type="checkbox"/>

Family history of: Cancer Diabetes Heart disease Anesthetic problems Asthma

Comments _____

