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MEDICAL HISTORY

Last Name:_____ First Name: _____ MI: _____

MEDICAL CONDITIONS (Please check all current and old diagnosis):

	Yes	No		Yes	No
Diabetes	☐	☐	Stroke	☐	☐
High Blood Pressure	☐	☐	Cancer or Tumor	☐	☐
Heart Valve Problem	☐	☐	Positive H.I.V. (AIDS)	☐	☐
Lung Problem	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	Any Joint Implants?	☐	☐
Liver Problem	☐	☐	Do you smoke? (Packs/Day:)	☐	☐
Kidney Problem	☐	☐	Do you drink Alcohol?	☐	☐
Stomach Problem	☐	☐	Do you use street drugs?	☐	☐
Intestine Problem	☐	☐	Glaucoma	☐	☐
Epilepsy	☐	☐	Osteoarthritis	☐	☐
Anemia	☐	☐	Rheumatoid Arthritis	☐	☐
Do you take antibiotics prior to surgery?	☐	☐	Blood Clotting Problem	☐	☐
Broken Foot or Ankle If yes, explain _____	☐	☐	*Female Patient*: Is there a possibility of you being pregnant today?	☐	☐

Other medical condition(s) not listed here:

List hospitalizations/surgeries in past:

ALLERGIES (to medication/drugs):

	Yes	No		Yes	No
Penicillin	☐	☐	Codeine	☐	☐
Sulfa Drugs	☐	☐	Iodine/Betadine	☐	☐
Aspirin	☐	☐	Novocain	☐	☐
Motrin (Ibuprofen)	☐	☐	Tapes/Adhesives	☐	☐
Other Anesthesia If yes, please list:	☐	☐	Food Allergies If yes, please list:	☐	☐

MEDICINES (List all medications you are now taking):