



Patient Medical History

Does the patient have any of the following conditions?

	Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>			

If yes to any above, please explain: _____

List any allergies to medications/anesthetics: _____

List any medications currently being taken: _____

List other doctors, treatments patient has had regarding same problem: _____

List previous surgeries: _____

List additional medication problems: _____

Additional comments: _____

Doctor's notes: _____

Doctor's Signature

Date