

Patient Label

Medical History Questionnaire

Escort:	
Height: Weight: Pain score today: out of 10	
Allergies: Date of last Center visit: _/	
Any Changes in Medical History since your last visit? YES (please complete form)	□N/ <i>E</i>
Please list all previous surgeries and hospitalizations: Please Ist all previous surgeries and hospitalizations Date Medical Condition Surgery	. [] 19/2
Please list all the medications you are taking (over the counter included) and the lass of day you took them: Medication	
Medication	time
Please list all previous surgeries and hospitalizations: Date Medical Condition / Surgery Date Medical Condition / Surgery Please check whether you have any of these conditions: Condition Yes No Condition Yes No Condition Yes Irregular Heartbeat / Arrhythmias Alcohol or recreational drug use Chest Pain Diabetes Family history w/anes. High blood pressure Hyperthyroidism Stroke Heart Attack Other Thyroid prob Seizures Heart murmur Gastric reflux Parkinson's Disease Heart catheterization Ulcers Other neuro problems Valve replacement Hiatal hernia MRSA/Staph infection Other Heart problems Other GI problems TB COPD Hill Vor AIDS Asthma/ Allergies Depression/BiPolar Hepatitis Chronic cough Psychiatric Disorders Other infectious prob Sleep Apnea Anemia Other infectious prob	
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Sleep Apnea Anemia	
Shortness of breath Evcessive bleeding	
Other respiratory prob Other bleeding Urinary or Kidney Disorders Urinary or Kidney Disorders	
Smoker packs per Any other Special needs: wheelchair,	
dayxyears conditions?? cane, etc	
Completed by: Reviewed by:	
Patient signature Date Nurse signature Date	