



**MEDICAL INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Medications: (If none, please check here ) \_\_\_\_\_

Allergies: (If none, please check here ) \_\_\_\_\_

Are you allergic to latex?  Yes  No If yes, what happens? \_\_\_\_\_

Previous operations: \_\_\_\_\_

Do you have, or have you had previously, and of the following (please check):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Irregular heartbeat      | <input type="checkbox"/> Psychiatric illness |
| <input type="checkbox"/> High cholesterol            | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Seizure             |
| <input type="checkbox"/> Blood clot in the leg (DVT) | <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Pulmonary embolus (PE)      | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Migraine headaches  |
| <input type="checkbox"/> Bleeding disorders          | <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Breast disease      |
| <input type="checkbox"/> Sickle cell disease         | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Stomach ulcers      |
| <input type="checkbox"/> Sickle cell trait           | <input type="checkbox"/> Pneumonia                | <input type="checkbox"/> Liver disease       |
| <input type="checkbox"/> Recent infection            | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> HIV/AIDS            |
| <input type="checkbox"/> Sleep apnea                 | <input type="checkbox"/> Kidney disease           | <input type="checkbox"/> Cold sores          |
| <input type="checkbox"/> Thyroid problems            | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Keloids             |
| <input type="checkbox"/> Reflux Disease (heart burn) | <input type="checkbox"/> Problems with anesthesia |  |

If you checked any of the above or have an unlisted medical condition, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke or use tobacco? \_\_\_\_\_ If so, how much? \_\_\_\_\_

Do you use smoke or use marijuana products? \_\_\_\_\_ If so, how much? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If so, how much? \_\_\_\_\_

Illnesses that run in your family (please include the family member that is affected):

\_\_\_\_\_

Has anyone in your family had problems with anesthesia?  Yes  No

If yes, please explain: \_\_\_\_\_

**Breast patients only**

Have you ever had an abnormal mammogram?  Yes  No

Last mammogram: \_\_\_\_\_