

HAVE YOU EVER HAD ANY PROBLEMS OR ALLERGIES TO ANY MEDICATION(S)?

YES NO If YES, please list below:

Name of Medication	Type of Reaction

PHARMACY PREFERENCE (include location): _____

SURGICAL & HOSPITALIZATION HISTORY:

Have you or a family member ever had malignant hyperthermia? YES NO

Have you ever had problems with anesthesia (being numbed or put to sleep)? YES NO

If yes, please list type of problems: _____

Please list any surgeries you have undergone or hospitalizations you have had (including dates):

Surgery/Hospitalization	Date

Please continue to next page

MARKING INSTRUCTIONS:
Please completely fill in the circle ●

Are you allergic to any of the following?

- None Adhesive/tape Metal
- Latex Contrast Dye Iodine

Mark below if you have been diagnosed with any of the following

Cancer

- Bone Cancer
- Breast Cancer
- Lung Cancer
- Multiple Myeloma
- Prostate Cancer
- Other _____

Heart and Blood Vessels

- Angina
- Coronary Artery Disease
- Stroke/CVA (cerebral vascular accident)
- Heart Failure
- Blood clot/DVT
- Heart Attack/MI (Myocardial infarction)
- HTN (Hypertension)/High Blood Pressure)
- MVP (Mitral valve prolapse)
- High Cholesterol
- Dysrhythmia/Irregular Heartbeat
- Varicose Veins/Peripheral Vascular Disease
- Pacemaker
- Other _____

Lungs and Respiratory

- Asthma
- (COPD)Chronic Obstructive Pulmonary Disease
- Emphysema
- TB (Tuberculosis)
- PE (Pulmonary Embolism)
- Sleep Apnea
- Other _____

Stomach and Digestive

- GERD
- Hepatitis – Type A
- Hepatitis – Type B
- Hepatitis – Type C
- Hepatitis – Type Other/Unspecified
- Peptic Ulcer
- Reflux
- Stomach Ulcer
- Hiatal Hernia
- Other _____

Kidneys and Urinary Tract

- Renal Failure
- Renal Insufficiency
- Chronic Kidney Disease
- (UTI) Urinary Tract Infection
- Other _____

Bones, Joints and Muscles

- Arthritis
- Gout
- Osteoporosis

- Scoliosis
- Prosthesis(es) e.g. artificial limb
- Other _____

Brain and Nervous System

- Epilepsy
- MS (Multiple sclerosis)
- Neuropathy
- Alzheimer's Disease
- Parkinson's Disease
- Dementia
- Other _____

Mental and Emotional Health

- Anxiety, chronic
- Bipolar Disorder
- Depression
- Panic Attacks
- Insomnia
- Other _____

Endocrine, Hormones and Metabolic Problems

- Diabetes – Type I
- Diabetes – Type II
- Diabetes – Type Other/Unspecified
- Thyroid Dysfunction
- Other _____

Blood and Lymph Node Problems

- Anemia
- Hemophilia
- Sickle cell disease/anemia
- Edema
- Other _____

Immune/Autoimmune and Infectious Problems

- AIDS
- HIV positive
- Lupus
- Rheumatoid Arthritis
- Other _____

Genitourinary

Females: Currently pregnant?

Other Problems Previously Diagnosed

Current type of work/occupation: _____

Have any family members been diagnosed with the following?

- Family history unknown No significant family health history
- Anesthesia problems Heart Disease
- Arthritis Osteoporosis
- Diabetes Bleeding/clotting problem

Current use of any of the following tobacco products:

- None Cigarettes Cigars Smokeless Tobacco

Give the closest amount of cigarettes you smoke in an average day:

- <1 cigarette 1-5 cigarettes ½ pack 1 pack
 1 ½ packs 2 packs 3+ packs Other: _____

History of use any of the following tobacco products:

- None Cigarettes Cigars Smokeless Tobacco

History of or current use of alcoholic beverages:

(A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer)

- None
 Abstainer (less than 12 drinks/yr)
 Light drink (1-13 drinks/month)
 Moderate/"Social" drinker (4-14 drinks/wk)
 Heavy drinker (>2 drinks/day)
 Binge drinker (drinks intermittently, 5 or more drinks/session)
 History of Alcoholism

Current use of any of the following drug(s):

- None Morphine Cocaine Meth
 Heroin Medical Marijuana Marijuana
 Other: _____

History of or current drug dependency or addiction:

- None Morphine Marijuana Meth
 Heroin Cocaine Diazepam (Valium) Soma
 Pain Medication: _____ Other: _____

Which is your dominant hand?

- Right Left Ambidextrous/neither

Do you currently have or recently had any of the following?

- Dizziness (Syncope)
 Night sweats
 Fever
 Unintentional weight loss/gain (circle one)

 Hearing loss
 Ringing in ears

 Blacking out or fainting
 Chest pain

 Shortness of breath or difficulty breathing

 Blood in stool
 Gastrointestinal bleeding
 Heartburn
 Constipation
 Diarrhea

 Unable to control bladder or bowel
 Increased frequency of urination

 Back pain
 Painful joints
 Swelling of joints

 Seizures

 Increased thirst
 Bleeds excessively after injury
 Bruises easily

Patient/Guardian Signature: _____

Date: _____

By signing here, I agree that I have completed these forms to the best of my knowledge and ability.