

Medical History Form

Patient Name: _____ Date of Birth: _____

1) Have you ever had any health problems with:

Heart _____ Diabetes _____

Lungs _____ Epilepsy _____

Kidney _____ High Blood Pressure _____

Liver _____ Low Blood Pressure _____

Asthma _____ Seizures _____

Cancer _____ Osteoporosis/Osteopenia _____

Depression/Anxiety/Mental Health _____

Reaction to anesthetic _____ Other Health Problems _____
(General, Local, Sedation)

2) Allergies: _____

3) Medications routinely used at home _____

4) Are you Pregnant? _____ If yes, how far along? _____ Nursing _____

5) Past surgeries:

Dates	Operation	Type of Anesthesia (General, local, Sedation)
_____	_____	_____
_____	_____	_____

6) Do you vape or smoke? _____ Packs per day/frequency? _____

Do you use cannabis? _____ Number of yrs of vaping/smoking/cannabis? _____

7) Do you drink alcohol? _____ How often? _____

8) Have you ever had any other health problems we should know about? _____

Patient's or Guardian's Signature

Date

Witness's Signature

Date

Doctor's Signature

Date