Medical History Form

(405)732-7777

Name: _____ Age:_____Date:_____

Please list all previous surgeries.

What medications do you take?

What are you allergic to?(drugs that cause a rash, itching, wheezing, or swelling)

Do you smoke? Yes___ No___Packs per day:____How Long?_____

Have you tested positive for Hepatitis, HIV, or any other infectious diseases?

Yes____ No____ if yes, which one?_____

Have you ever had a staph infection? Yes____No____

Please circle yes or no if you had any of the following:

Heart disease/Heart valve disease	Yes / No	Diabetes	Yes / No
Pulmonary Disease	Yes / No	Asthma	Yes / No
High Blood Pressure	Yes / No	Sickle Cell Disease or Trait	Yes / No
Pace Maker/ Defibrillator	Yes / No	Tuberculosis	Yes / No
Prosthesis/ Implants Metal	Yes / No	Heart Attack	Yes / No
Heart Failure	Yes / No	Heart Murmurs	Yes / No
Chest Pain/ Angina	Yes / No	Heart Rhythm Irregularities	Yes / No
Circulation Problems	Yes / No	Blood Transfusions	Yes / No
Abnormal Bleeding Tendencies	Yes / No	Abnormal Chest X-Rays	Yes / No
Bronchitis	Yes / No	Emphysema	Yes / No
Pneumonia	Yes / No	Kidney Disease	Yes / No
COPD	Yes / No	Cancer _____	Yes / No

Do you or anyone in your family have abnormal reactions to anesthesia Yes / No

Have You ever had a blood clot?