MEDICAL INFORMATION SHEET				PERSONAL MEDICAL CONDITIONS	YES	NO
NAME:	AGE:			Thyroid problems		
Sign/Date:				Seizures or epilepsy		
HEIGHT:	WEIGHT:			Liver disorder including hepatitis or cirrhosis		
CHIEF COMPLAINT:				Kidney/bladder disorders or chornic infections		
				Spinal or back disorders		
OCCUPATION:				Previous blood clots or thrombophlebitis		
GENERAL MEDICAL EVALUATION:		YES	NO	Any bleeding disorders in self or in family		
Who is your family/general medical doctor?				Blood transfusions		
How is your general health?				Diabetes		
Are you now being treated for any medical				Auto-immune diseases (lupus, theumatoid arthritis, HIV)		
conditions?				Cold sores/fever blisters or herpes?		
If yes, please specify:				Any unusual healing problems		
				Do you form keloids or thick scars?		
When was your last physical examination?				If any of the above are "yes", explain:		
Do you have children?	Ages?			ALLERGIES	YES	NO
				Any *medication* allergies		
WOMEN ONLY: Are you pregnant:				**If "yes", please list Medication and Reaction**:		
Last menstrual period?						
Are you taking Birth Control Pills?				Any problems with anesthesia?		
Have you had a hysterectomy or tubal ligation?				Tape Allergy?		
Have you had a mammogram?				Are you allergic to latex?		
If yes, when and where was your last mammogram?				SOCIAL	YES	NO
				Do you smoke?		
CARDIOVASCULAR	YES		NO	If so, how many packs per day?		
Coronary or heart attack				Do you use other tobacco products?		
Congenital heart discase (at birth)				If so, what type?	How often?	
Heart murmur				Do you drink more than two alcoholic beverages a day?		
Rheumatic Fever				Do you/or have you had a drug or alcohol		
Palpitations or irregular heart beat				dependency or treatment?		
Prolapsing valve				MENTAL HEALTH	YES	NO
High blood pressure				Have you received psychiatric treatment/couseling?		
Stroke				If yes, were you hospitalized?		
RESPIRATORY:		YES	NO	Please explain:		
Shortness of Breath						
Chronic lung disease				FAMILY HISTORY:	YES	NO
Cough				Any medical problems or illness in your family?		
Asthma				Explain:		
MEDICATIONS:		YES	NO	Does anyone in your family have any problems		
Have you taken any steroid (cortisone)				with anesthesia?		
preparations in the last year?				Explain:		
Date of last tetanus shot?						
PREVIOUS SURGERYS						

Type of surgery/reason	Hospital	Surgeon/Doctor	Date	Complications/problems

List any medications you currently take and the dosage: