Name: ____ Today's date: _____________________

PAST MEDICAL HISTORY

In each area, if you have no history please check "None". If you have a history of any item listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask the medical assistant, or your doctor.

☐ **None of the items apply**

Anemia
Anesthesia complications
Angina
Anxiety
Asthma
Kidney disease
Atrial flutter
Autoimmune disorder
Blood transfusions
Brain tumor
Cancer type __________________
Congestive heart failure
COPD
Coronary heart disease
Crohn's disease
Stroke
Deep vein thrombosis
Diabetes type 1
Diabetes type 2
Diverticulitis
Endocarditis
GERD (acid reflux)
Heart block
Heart Block

Hemochromatosis
Hepatitis
HIV
High cholesterol
Hypertension
Hypothyroidism
Hyperthyroidism
Kidney stone
Liver disease
Heart attack
Neurological disorder
Osteoarthritis
Osteoporosis
Pulmonary embolism
Ulcers
Rheumatoid arthritis
Seasonal allergies
Seizure disorders
Syncope (fainting)
Depression
Tuberculosis
Valvular heart disease
Other:

Medications: ____
____
____

Medication Allergies:____
____

All Prior Surgeries:____
____