Medical Questionnaire

Patient Name____ Date_____/_____/_____

Please fill out and return with your consent.

Past Medical History please X all that apply (Are you or have you been treated for any of these?)

Diabetes ☐

Cardiac ☐

Blood Pressure ☐

Hepatitis ☐

Aids ☐

Mitralvalve Prolapse ☐

Liver ☐

Kidney ☐

Thyroid ☐

Past Anesthesia History

Are you taking any Medications – please list:

Reactions to any Medications – please list:

Using any Recreational drugs – please list:

Latex Allergies - Yes ☐ No ☐

Tape Allergies Yes ☐ No ☐

Have you had local anesthesia? Yes ☐ No ☐

Have you had general anesthesia? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ How much?__________a day / week

Do you Drink Spirits ? Yes ☐ No ☐ How much?__________a day / week

Past Surgical History

Date_____/_____/_____ Procedure____

Date_____/_____/_____ Procedure____

Date_____/_____/_____ Procedure____

Date_____/_____/_____ Procedure____

Date_____/_____/_____ Procedure____

Date_____/_____/_____ Procedure____