

## Confidential Medical History

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please complete all requested information.

1. Do you smoke?    Yes        No                      Year you stopped smoking: \_\_\_\_\_

2. Please list nay and all hospitalizations and/or operations you have had.

Date	Purpose of Hospital Visit	Type of Surgery
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_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Do you ever or have you ever had any allergic reaction to any prescription or non-prescription medications or drugs?        Yes        No

If yes, please answer below:

Name of medication: \_\_\_\_\_

Any other Reactions: \_\_\_\_\_

Any other Allergies: \_\_\_\_\_

Do you have a Latex allergy? \_\_\_\_\_

4. Have you ever had any of the following?

Heart Problems	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Liver Problems	Yes	No
Amenia	Yes	No	Stroke	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No
Circulation Problems	Yes	No	Dizzy Spells	Yes	No
Seizures	Yes	No	Cancer	Yes	No

5. Have you ever been treated for depression?        Yes    No    If so, when? \_\_\_\_\_

6. Any serious illnesses/conditions not mentioned? Please specify: \_\_\_\_\_

7. Have you known or suspected exposure to TB, Hepatitis B, C, of HIV?        Yes        No

If yes, please detail all information possible, including years of exposure: \_\_\_\_\_

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**Please inform us if any information changes.**