Medical History

(Patient Label)

Date: ____________________

Information Source: ☐ Patient ☐ Other ____________________

Is English your main language? ☐ Yes ☐No

PREFERRED LANGUAGE:____________________

Reason for Admission:

Who Makes Your Healthcare Decisions: ____________________

Relationship:____________________Telephone: ( )

Primary Contact (If Different from above): ____________________

Relationship:____________________Telephone: ( )

Allergies (Describe):

Prior Surgical History (list & include dates):

Date:	Procedure:

Any Anesthetic Complications? ☐ Yes ☐ No

If YES Specify: ____________________

INFECTION CONTROL / TB ASSESSMENT

	Yes	No	Comments
Previous history of or Active Tuberculosis			
Fever, chills or night sweats			
Cough or coughing up blood			
Positive TB skin test			
Recent travel (or native) of area with high incidence of TB (Asia, Latin America, Africa, Caribbean)			
Recent immunosuppressed status (Chemotherapy, Radiation transplant, HIV, steroids)			
Unintentional weight loss (> 10 lbs. In past 3 mos)			
MRSA / VRE History			Location:

Medical History	Yes	No	Comments
Pain (Acute/Chronic)			Location:
Cancer			Location:
Arthritis/Limited Joint Motion			Location:
Stroke			
Confusion			
Heart Disease			
Chest Pain/Angina			
Heart Palpitations			
High Blood Pressure			
Heart Murmur			

Medical History	Yes	No	Comments
Vascular Disorder			
Lung Disease			
Shortness of Breath			
Asthma			
Emphysema			
Sleep Apnea			
Recent Cold/Cough			
Tuberculosis			
Stomach Problems			
Acid Reflux			
Kidney/Bladder Problems			
Thyroid Problems			
Diabetes			
Liver Disease/Hepatitis			
Bleeding Problems/Anemia			
Sickle Cell			
Psychiatric Illness/Depression			
Female Problems			
Last Menstrual Period			Date:
Chance of Pregnancy			
Implanted Devices			
Prosthesis (Type)			
Hearing Aid (R/L)			
Dentures/Partial (Upper/Lower)			
Glasses/Contacts (R/L)			
Recreational Drugs			Amt./Freq.
Alcohol			Amt./Freq.
Smoking Status (Check One):			
Nonsmoker			
Former greater than 1 year			Amt./Freq.
Former less than 1 year			Amt./Freq.
Current Smoker			Amt./Freq.
Have you had a previous fall in the last year?			
Do you have dizzy spells or problems walking?			

FOR PEDIATRIC PATIENTS:

Medical History	Yes	No	Comments
Congenital Syndrome			
Cerebral Palsy			
Cleft Lip/Palate			
Seizures			
Learning Disability			
Immunization Up To Date			
Last Bowel Movement			