Medical History

Name: ____ **Age**: ________

Family History:

	Mother	Father	Mothers Parents	Fathers Parents
Heart attack	☐ Age_____	☐ Age_____	☐	☐
Diabetes	☐	☐	☐	☐
Lung problems	☐	☐	☐	☐
Problems with anesthesia	☐	☐	☐	☐
Arthritis	☐Type__________	☐Type__________	☐Type__________	☐Type__________
Cancer	☐Type__________	☐Type__________	☐Type__________	☐Type__________

Social History: Do you

Smoke Yes ☐ No ☐ Packs per day________ Years Smoked _________

Drink Yes ☐ No ☐ Drinks per Day______

Abuse drugs Yes ☐ No ☐ Type______________________________

Work (what type of work) ____

Are you married? Yes ☐ No ☐

Childhood Illnesses: (check ✓ if applicable)

- ❑ Measles
- ❑ Rubella
- ❑ Mumps
- ❑ Chicken Pox
- ❑ Other _________

Adult Illnesses: (check ✓ if applicable)

- ❑ Diabetes
- ❑ Lung Disease
- ❑ Hepatitis
- ❑ Heart Attack
- ❑ Other ________
- ❑ Arrythmia
- ❑ Aids

Injuries: (List head injuries, broken bones, back injuries, and date)

____

____

Prior Surgeries: (List type, date and any complications)

____

____