# Personal Medical History

**NAME:** ______________________________

**Date of Birth:** ________________________

**Age:** _________________________________

**Height:** ______________________________

**Weight:** ______________________________

**LIST ALL PREVIOUS SURGERIES**

| Surgery | Surgeon | Date |
|---|---|---|
| | | |
| | | |
| | | |

## Have you had an adverse reaction to:

Anesthesia
Antibiotics
Codeine
Demerol
Adhesive tape
Aspirin
Sulfur
Penicillin
Valium
Iodine
Morphine
Suture material
OTHER: ________________________________

## Do you have a history of:

Asthma
Bleeding disorders
Seizures, epilepsy
Hernia
Shortness of breath
Bronchitis, chronic cough
Tuberculosis
Depression
Osteo-rheumatoid arthritis
Lupus or autoimmune disease
Hypertension
Blood clots
Diabetes
Headaches
Blood pressure medication
Cardiac medication
Thyroid disease
Hepatitis A B C
Mitral valve prolapse (heart murmur)
Drug abuse
Alcoholism
OTHER: __________________________________

**INSURANCE INFORMATION**

**Carrier:** ______________________________

**Group No.:**___________________________

**Policy No.:**___________________________

**PRIMARY PHYSICIAN**

**Name:** ______________________________

**Telephone No.:**____________________

**EMERGENCY CONTACT**

**Name:** _______________________________

**Address:**____________________________

**Phone No.:**___________________________

**Relationship:**________________________

## Do You Take:

Blood pressure medication
Cardiac medication
Diet pills
Diuretics
Vitamins, herbal supplements
Tranquilizers
Alcohol
Sleeping pills
Anti-depressants
Pain medications
HRT
Aspirin or other anti-inflammatory drug
OTHER: __________________________________

**LIST ALL CURRENT MEDICATIONS:**

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**ALLIERGIES:**

______________________________________

______________________________________

**OTHER EMERGENCY INFORMATION**