MEDICAL HISTORY FORM

PATIENT NAME: _____ **AGE:** _____ **DATE:** _____

PRIMARY CARE PHYSICIAN: _____

REASON FOR CONSULTATION : _____

HEALTH PROBLEMS OR CONDITIONS: _____

_____

OPERATIONS:

TYPE	DATE	COMPLICATIONS

MEDICATIONS: (including vitamins and herbal supplements)

TYPE	DOSAGE AMOUNT	TAKEN HOW OFTEN

ALLERGIES: **[ ] NO [ ] YES (please provide details below)**

_____

TOBACCO USE: **[ ] NO [ ] YES How many per day** _____

ALCOHOL USE: **[ ] NO [ ] YES How many per day** _____

Do you bruise or bleed easily? (with cuts, tooth extraction, pregnancy, surgery)	**[ ] NO**	**[ ] YES**
Do you have a family history of bleeding problems?	**[ ] NO**	**[ ] YES**
Have you ever had a blood transfusion?	**[ ] NO**	**[ ] YES**
Are you opposed to receiving a blood transfusion?	**[ ] NO**	**[ ] YES**
Have you had a bad reaction while being put to sleep for surgery?	**[ ] NO**	**[ ] YES**
Have any of your family members ever had problems with anesthesia?	**[ ] NO**	**[ ] YES**
Are you pregnant?	**[ ] NO**	**[ ] YES**
Is it possible you could be pregnant?	**[ ] NO**	**[ ] YES**
Are you allergic to latex?	**[ ] NO**	**[ ] YES**
Are you allergic to tape?	**[ ] NO**	**[ ] YES**
Have you had a cortisone injection in the last year?	**[ ] NO**	**[ ] YES**
Regular aspirin use?	**[ ] NO**	**[ ] YES**
Regular use of Ibuprofen, Advil, Motrin?	**[ ] NO**	**[ ] YES**

HAVE YOU EVER BEEN EXPOSED TO:

INTRAVENOUS DRUGS	**[ ] NO**	**[ ] YES**	**HIV**	**[ ] NO**	**[ ] YES**
INFECTIOUS DISEASES	**[ ] NO**	**[ ] YES**	**BLOOD TRANSFUSION**	**[ ] NO**	**[ ] YES**
TB	**[ ] NO**	**[ ] YES**	**LIVER TRANSPLANT**	**[ ] NO**	**[ ] YES**
HEPATITIS	**[ ] NO**	**[ ] YES**			

OTHER HEALTH PROBLEMS OR CONDITIONS, CURRENT OR PAST: please provide details

Anesthesic Complications	**[ ] NO**	**[ ] YES**	_____
Anemia	**[ ] NO**	**[ ] YES**	_____
Asthma	**[ ] NO**	**[ ] YES**	_____
Bruise or Bleed Easily	**[ ] NO**	**[ ] YES**	_____
Blood Clots in Legs or Lungs	**[ ] NO**	**[ ] YES**	_____
Cancer	**[ ] NO**	**[ ] YES**	_____
Diabetes	**[ ] NO**	**[ ] YES**	_____
Endocrine / Hormone Disorder	**[ ] NO**	**[ ] YES**	_____
Heart Disease / High Blood Pressure	**[ ] NO**	**[ ] YES**	_____
HIV (AIDS)	**[ ] NO**	**[ ] YES**	_____
Hypertension	**[ ] NO**	**[ ] YES**	_____
Infections / Immune System Disorder	**[ ] NO**	**[ ] YES**	_____
Kidney Disease	**[ ] NO**	**[ ] YES**	_____
Liver Disease / Hepatitis	**[ ] NO**	**[ ] YES**	_____
Lung Disease / Asthma	**[ ] NO**	**[ ] YES**	_____
Neurological Disease / Seizures	**[ ] NO**	**[ ] YES**	_____
Psychiatric / Mental Disorder	**[ ] NO**	**[ ] YES**	_____
Stomach / Intestinal Disease	**[ ] NO**	**[ ] YES**	_____

EMOTIONAL HISTORY:

Do you have any significant emotional problems? **[ ] NO** **[ ] YES (please explain)**

_____

Have you ever had Psychiatric/Psychological Care? **[ ] NO** **[ ] YES (please explain)**

_____

Have you ever been diagnosed with Body Dysmorphic Disorder? **[ ] NO** **[ ] YES**

FAMILY MEDICAL HISTORY

Do any of your relatives have any of the following? (if yes, who)

Tuberculosis	**[ ] NO**	**[ ] YES**
Cancer	**[ ] NO**	**[ ] YES**
Diabetes	**[ ] NO**	**[ ] YES**
Epilepsy	**[ ] NO**	**[ ] YES**
Heart Disease	**[ ] NO**	**[ ] YES**
High Blood Pressure	**[ ] NO**	**[ ] YES**
Lung Disease	**[ ] NO**	**[ ] YES**
Kidney Disease	**[ ] NO**	**[ ] YES**
Blood or Bleeding Disorder	**[ ] NO**	**[ ] YES**
Asthma	**[ ] NO**	**[ ] YES**
Mental Disorder	**[ ] NO**	**[ ] YES**

I certify that I am a mentally competent adult at least 18 years of age, and that I have read this form and answered all questions truthfully and to the best of my knowledge. I am responsible to notify the office and the physician if any changes occur in my medical condition. If I fail to keep the doctor informed of my full medical history, I may be at an increased risk for complications or unexpected results from the planned treatments.

Witness _____ **Patient** _____

I certify that I am a mentally competent parent or legal guardian of the minor or mentally incompetent patient, and that I have read this form and answered all questions truthfully and to the best of my knowledge.

Witness _____ **Parent or Legal Guardian** _____

Medical History reviewed and discussed with Kouros Azar, M.D. _____