



Medical History II

Name: _____ Age: _____

Weight: _____ Height: _____

Date of Last Physical Exam: _____ CXR: _____ EKG: _____

Have you ever had: **Yes** **No**

Surgery requiring anesthesia:

Any complications or ill effect
related to anesthetic:

Any blood relative who had
anesthesia complications of
any kind:

Chest pain, shortness
of breath:

Palpations or fluttering
of the heart:

Pneumonia:

Rheumatic fever or
heart disease:

Anemia:

Jaundice or liver disease:

Diabetes (sugar in blood):

High or low blood pressure:

Asthma or hay fever:

Frequent colds or sore throat:

Blood or plasma transfusion:

Chronic cough:

Fainting spells:

Do you have: (Circle each)

Dentures, capped teeth, bridges, loose teeth,
diseased gums, contact lenses, hearing aid,
prosthetic device(s), glasses

List Current Medications

Allergies

Tape Yes No

Any Drugs Yes No

Specify: _____

Habits: (Circle each)

Alcohol: Never Rarely Daily

Tobacco: Never Rarely Daily

Number of packs per day: _____

List Previous Surgeries

Please list any other health problem(s) that you might have:
