

Medical History

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)			Amt./Freq. _____
Recreational Drugs			Amt./Freq. _____
Alcohol			Amt./Freq. _____
Smoking Status (Check One):			
Nonsmoker			Amt./Freq. _____
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			