NAME_____ _____ _____ DATE_____
FIRST MIDDLE LAST

# MEDICAL HISTORY

1. **Who are your medical doctors?**
   **Name**_____**Phone #**_____**Specialty**_____
   **Name**_____**Phone #**_____**Specialty**_____
   **Name**_____**Phone #**_____**Specialty**_____

1. **List current medications (By prescription and over the counter)**
   **Drug**_____**Dosage**_____**Indication**_____
   **Drug**_____**Dosage**_____**Indication**_____
   **Drug**_____**Dosage**_____**Indication**_____
   **Drug**_____**Dosage**_____**Indication**_____
   **Drug**_____**Dosage**_____**Indication**_____

- Do you take anticoagulants (blood thinners) like Aspirin, Coumadin, Jantoven, Plavix, Pradaxa, Ticlid, Xarelto?
  Yes☐ No☐
- **List**_____
- Do you take bisphosphonate for osteoporosis like Actonel, Atelvia, Boniva, Didronel, Fosamax, Prolia?
  Yes☐ No☐
- **How long have you been taking it?**
- Do you have a prosthetic heart valve, a history of infective endocarditis (heart inflammation), congenital heart disease (at birth) or a heart transplant?
- **Yes☐ No☐ Which one?**_____
- Have you had a joint (knee, hip, shoulder) replaced in the last two years?
- **Yes☐ No☐**
- Have you ever had radiation treatment to the head or neck area?
- **Yes☐ No☐ How long ago?**_____
- Are you currently undergoing chemotherapy? Yes☐ No☐
- Do you have cirrhosis of the liver? Yes☐ No☐
- Do you have any problem or family history of bleeding problems (blood coagulation or bleeding easily)?
  Yes☐ No☐
- Have you had any problem with anesthesia medications in the past? Yes☐ No☐
- Have you had any heart stent or surgery in the last year? Yes☐ No☐
- Do you have any breathing problems? Yes☐ No☐
- Do you have any other medical condition or disease not covered above? Yes☐ No☐
  List_____
- Are you allergic to any medications? Yes☐ No☐ List_____
- Are you allergic to latex products? Yes☐ No☐
- Do you use tobacco products? Yes☐ No☐
- **How much per day?**_____**How long (years)?** _____

**FEMALES ONLY:**

**Are you pregnant or think you might be pregnant? Yes☐ No☐**
**Are you nursing? Yes☐ No☐**
**Are you taking birth control pills? Yes☐ No☐**

**I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.**

_____ _____
**Signature (Patient, parent or guardian)** **Date**