PATIENT HISTORY

NAME: _____ RACE/ETHNICITY: _____
ETHNICITY: Hispanic / Non-Hispanic (circle one)
PRIMARY LANGUAGE SPOKEN: _____
PERSON ABLE TO TRANSLATE (IF NECESSARY):

_____
Name Phone Number

HEIGHT: _____ WEIGHT: _____

Please circle YES or NO for each question, sign your name and fill in the date at the end of the form.

1. Have you ever taken, or are you currently taking Flomax (Tamsulosin) Yes No
2. Are you currently taking Cardura (Doxazosin), Hytrin (Terazosin), Uroxatral (Alfuzosin), or Minipress (Prazosin)? Yes No
3. Have you ever been told you have MRSA (Methicillin-resistant Staphylococcus aureus)? Yes No
   If yes, where (example: lungs, wound, etc.) _____
4. Do you have an irregular heartbeat or any trouble with your heart? Yes No
5. Do you have high blood pressure? Yes No
6. Have you ever had a stroke / TIA (Transient Ischemic Attacks)? Yes No
   If yes, when _____
7. Do you have asthma, emphysema (COPD), or Sleep Apnea? (Circle) Yes No
8. Have you ever had a heart attack? Yes No
   If yes, when _____
9. Any history of epilepsy or seizures? Yes No
10. Have you had rheumatic fever? Yes No
11. Are you a diabetic? Yes No
    If yes, list type and amount of drug taken for diabetes
    _____
12. Do you smoke or use tobacco? Yes No
    If yes, how much? _____
13. Have you received a Pneumonia vaccination? Yes No
14. Have you received an Influenza vaccine (Flu shot) this season? Yes No
15. Do you have multiple sclerosis? Yes No
16. Have you had a persistent cough for over 3 weeks? Yes No
    A. Is there blood in the sputum? Yes No
    B. Any elevated temperature (over 100˚F in the last week?) Yes No
    C. Are you having night sweats? Yes No
    D. Any recent unexplained weight loss? (5% in the last 3 months) Yes No
    E. Any known contact with TB, or have you been diagnosed with TB? Yes No
17. Have you ever been diagnosed with cancer? Yes No
    If yes, type of cancer _____
18. Do you have false teeth, caps or contact lenses? (Circle all that apply) Yes No
19. Have you ever had jaundice or hepatitis? Yes No
20. Have you ever been tested for HIV (AIDS)? Yes No
    If yes, when and what were the results? _____

21. Have you ever had any problems with mental illness? Yes No

22. Have you ever been told you are a bleeder? Yes No

23. Do you have frequent headaches or migraines? Yes No

24. Have you ever had a head injury or brain tumor? (circle) Yes No

25. Have you ever lost consciousness? Yes No

26. Do you use alcohol? If so, frequency: _____ Yes No

27. Do you currently use pain medication with narcotics? Yes No

28. Do you use recreational drugs? Yes No

29. Have you ever had a blood transfusion? Yes No
If so, when: _____ where: _____

30. Have you ever had general anesthesia? Yes No
If so, date of the last time:_____

31. Have you ever had a reaction to local or general anesthesia Yes No
If yes, what kind of reaction:_____

32. Please list all of the operations you have had. Give dates (Month/Year)

_____

_____

33. Any family history of anesthetic problems, including sudden death or malignant hyperthermia (an unusually increased temperature after anesthesia)? Yes No

34. Have you ever had any of the following problems? If yes, please mark.

☐ Glaucoma	☐ Blindness	☐ Cataract
☐ Retinal Disease	☐ Crossed Eyes	☐ Macular Degeneration
☐ Retinitis Pegmentosa	☐ Lazy eye	☐ Cranial or Temporal Arteritis
☐ Serious Eye injury	☐ Optic Neuritis	☐ Keratoconus

35. Family History	Living		General Health	Cause of Death
Mother	Yes	No	_____	_____
Father	Yes	No	_____	_____
Brother(s)	Yes	No	_____	_____
Sister (s)	Yes	No	_____	_____

36. If you have any medical problems not covered by the above questions - such as... thyroid problems, cholesterol problems, fibromyalgia, etc. please note:

_____

_____

SIGNATURE:_____ **DATE:**_____