

MEDICAL HISTORY

Current Date _____ Name _____ DOB _____

Primary Care Practitioner _____

No Heart Problems **Notes**

High Blood Pressure	<input type="checkbox"/> Yes	
Heart Attack-Last 6 Months	<input type="checkbox"/> Yes	
Chest Pain-Last 6 Months	<input type="checkbox"/> Yes	
Pacemaker/Defibrillator	<input type="checkbox"/> Yes	
Other	<input type="checkbox"/> Yes	

Drug Allergies/Reactions NKDA

1.
2.
3.
4.
5.

No Lung Problems

COPD/Emphysema	<input type="checkbox"/> Yes	
Asthma	<input type="checkbox"/> Yes	
Sleep Apnea	<input type="checkbox"/> Yes	
Recent Pneumonia	<input type="checkbox"/> Yes	
Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> Quit

List Recent Major Surgeries - Last 6 Months

1.
2.
3.

No Neurological Problems

Stroke or TIA	<input type="checkbox"/> Yes	
Deficits?	<input type="checkbox"/> Yes	
Cane	Crutches	Walker
Wheelchair		
Multiple Sclerosis	<input type="checkbox"/> Yes	
Dementia	<input type="checkbox"/> Yes	
Mental Illness	<input type="checkbox"/> Yes	
Seizure disorder	<input type="checkbox"/> Yes	
DBS/Cochlear Device	<input type="checkbox"/> Yes	
Other	<input type="checkbox"/> Yes	

Anesthesia Complications

No Yes

Are you, or could you be pregnant

No Yes Unknown

No Gastrointestinal Problems

Reflux	<input type="checkbox"/> Yes	
Alcohol use	<input type="checkbox"/> Yes	

Office Use

Ht	Wt	BMI
Date	PSC Init.	MD

No Metabolic Problems

Diabetes	<input type="checkbox"/> Type I	Type II	
A1C	BG		
Renal failure/dialysis	<input type="checkbox"/> Yes		

No Other Problems

Autoimmune disease	<input type="checkbox"/> Yes	
Cancer	<input type="checkbox"/> Yes	
HIV, Hepatitis A/B/C	<input type="checkbox"/> Yes	
Any Current Active Infection	<input type="checkbox"/> Yes	
On Blood Thinners?	<input type="checkbox"/> Yes	INR:
Fever	<input type="checkbox"/> Yes	
Hearing Aids?	<input type="checkbox"/> Yes	
Other:	<input type="checkbox"/> Yes	

No Prostate-like medications used

Tamsulosin (Flomax/Jalyn)	<input type="checkbox"/> Yes	
Terazosin	<input type="checkbox"/> Yes	
Doxazosin	<input type="checkbox"/> Yes	
Alfuzosin	<input type="checkbox"/> Yes	
Sildenafil	<input type="checkbox"/> Yes	
Saw Palmetto	<input type="checkbox"/> Yes	
SEE ATTACHED MEDICATION LIST		

Patient Information

COVID-19 Screening

Travel	<input type="checkbox"/> No	
Symptoms	<input type="checkbox"/> No	
Exposure	<input type="checkbox"/> No	