RENAISSANCE

MEDICAL/SURGICAL HISTORY

Patient Name ______________________ Date ______________________

Procedure ______________________

Describe in your own words the reason for your visit to our office. Also, give names of any physician contacted regarding this problem.

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In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We, therefore, ask that you give us the following medical information.

Age:	Height:	Weight:	Occupation:
List all Drug Allergies:			
Do you have an allergy to Latex? □ yes □ no			
Are you a smoker? □ yes □ no Ex-smoker? □ yes □ no Non-smoker? □ yes □ no			
How much are (were) you smoking?	How long?	Quit: how long?	
How much alcohol do you drink?	Caffeine?		
Please circle all of the following medical conditions you now have or have had in the past:			
Mitral Valve Prolapse / bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / breast cancer / heart attack / stroke / epilepsy / heartburn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / cancer / kidney disease / breast disorders / skin cancer / melanoma / high blood pressure / rheumatoid arthritis / scleroderma / lupus / autoimmune disease / unexplained weight loss / chronic fatigue / positive HIV/AIDS test / fever blisters / sleep apnea			
Any possibility that you may be pregnant at this time? □ yes □ no	last cycle		
Number of pregnancies:	Last Tetanus shot:		
Have you had any serious injuries, broken bones, etc.? □ yes □ no			
Have you or anyone in your family had an unusual reaction to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fever)? □ yes □ no			
Do you have any: (circle one) loose or chipped teeth / dentures / caps / contact lens?			
Have you ever seen a Cardiologist? □ yes □ no			
Name:	Address:		
City: State: Zip:	Date of last EKG:		
Family Physicians Name:	Date of last visit:		
Address:	City: State: Zip:		

MEDICAL/SURGICAL HISTORY

Patient Name ______________________ Date ______________________

List all surgeries that you have had (include plastic surgery):	Date:
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________

Please list all medications which you are currently taking or have used in the past 6 months:		
Be sure to list any of the following: birth control, aspirin or ibuprofen containing drugs, Redux Phen-Fen, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medication, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, anti depressants, pain pills or shots, epilepsy medications.		
Medications:	Amount:	Frequency:
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________

Is there any other information we should know about you or your family? □ yes □ no

Please circle all of the following medical conditions that anyone in your family presently or has had in the past:

bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / breast cancer / heart attack / stroke / epilepsy / heartburn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / cancer / kidney disease / breast disorders / skin cancer / melanoma / high blood pressure / rheumatoid arthritis / scleroderma / lupus / autoimmune disease / unexplained weight loss / chronic fatigue / mitral valve Prolapse

Family Member:	Alive	Deceased	Age	Cause
Father	□	□		
Mother	□	□		
Siblings	□	□		
Siblings	□	□		
Children	□	□		
Children	□	□		

Patient Signature:
Date: