MEDICAL HISTORY FORM

Patient Name:	Date of Birth:

MEDICAL ALERT Do you have any of the following:

History of Blood Clot or PE (Pulmonary Embolism)	☐ **YES**	☐ **NO**
Pacemaker	☐ **YES**	☐ **NO**
Defibrillator	☐ **YES**	☐ **NO**
Emergency Nitroglycerin	☐ **YES**	☐ **NO**
Inhaler	☐ **YES**	☐ **NO**
History of MRSA infection	☐ **YES**	☐ **NO**
Topical Iodine Allergy	☐ **YES**	☐ **NO**
Latex Allergy	☐ **YES**	☐ **NO**
Rapid Heartbeat with Epinephrine	☐ **YES**	☐ **NO**
Sleep Apnea / CPAP Machine	☐ **YES**	☐ **NO**
Glaucoma	☐ **YES**	☐ **NO**

Do you take a prescription blood thinner? **YES / NO**

If YES, name of the provider managing your blood thinner: _____

Provider's Phone Number: _____Fax Number: _____

MEDICATIONS List all your current medications including prescriptions, OTC, Vitamins and Herbal Supplements or write "NONE"

Medication Name:	Dosage:	Frequency:	Reason for Taking:

MEDICAL HISTORY List all past and present medical conditions (example: High Blood Pressure, Diabetes, Stroke) or write "NONE"

ALLERGY AND SENSITIVITY List any allergies or sensitivities and the type of reaction or write "NONE"

Allergy/Sensitivity:	Type of Reaction:

Patient Signature_____Date_____

Surgeon Signature _____Date_____