Patient Medical History Information

Last Name ______________________First Name_________________________

To avoid duplication, on the day of testing bring: any recent lab reports, chest X-ray report from a radiologist, and /or ECG tracings with an internist or cardiologist report.
For questions, please call (303) 909-6977.

A. Have you ever had any of the following?:

	YES	NO	Doctor's Name/Where	Year
An exam by a Cardiologist (Heart Doctor)				
Heart Catheterization				
Exercise Stress Test				
Ultrasound of Heart (Echocardiogram)				
Pacemaker				

B. To your knowledge, do you now have or have you ever had any of the following?:

	YES	NO		YES	NO		YES	NO
Loose or Chipped Teeth			Mitral Valve Prolapse			Epilepsy/Seizures		
Caps/Bridges/Dentures/ Bonding Root Canal/Crowns			Do you take Predental Antibiotics			History of Anemia (Low Blood Count)		
Temporal Mandibular Joint Dis.			Chronic Heartburn			Sickle-Cell Anemia/Trait		
Recent Cold, Bronchitis Or Pneumonia			Hiatal Hernia			History of bleeding or bruising		
History of Asthma or Wheezing			Stomach Ulcer			Excess bleeding from Surgery		
Tuberculosis or Silicosis			Kidney Disorder			Blood Transfusion		

STAPLETON | 2975 Roslyn Street, Suite 140 Denver, CO 80238
THORNTON | 9141 Grant Street, Suite 125, Thornton, CO 80229
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MILE HIGH plastic surgery

Sleep Apnea			Thyroid Disorder			If Blood products are needed, is your surgeon aware of your preference?		
Shortness of breath at rest or with limited exercise			Diabetes			Are you a Jehovah's Witness		
Chronic Cough or Lung Problems			Liver Disease, Jaundice, Hepatitis			If Yes, Is your Surgeon Aware		
High Blood Pressure			Stroke/TIA			Phlebitis/ Blood Clots		
Chest Discomfort or Tightness with Exercise, Angina			Weaknesses or Paralysis			Problems with Poor Circulation to Feet/Legs		
Irregular Heart Beat, Palpitations			Multiple Sclerosis or Polio			Skin Problems		
Heart Attack			Head Injury			Hearing Problems		
Heart Failure			Chronic Back Problems			Vision Problems		
Rheumatic Fever			Scoliosis (Curvature of Spine)			Do you use any of the following: Cane, Walker, Crutches, Wheelchair		

C. Do you have any special concerns?

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D.

1. Do you or have you ever smoked (including pipe/cigars)? Yes No
   Number of packs/cigars per day _____ Number of years _____ When was your last cigarette, cigar, pipe?
2. Do you drink alcoholic beverages on a weekly basis? Yes No
   If yes, how much do you typically drink in one week?________________________________

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3. Are you Pregnant? Yes No Not Applicable Not Sure
   Date of last menstrual period______________
   (On the morning of surgery, please advise you anesthesiologist if there is any possibility you may be pregnant.)
4. Height _____________ Weight _____________

E. Please List All Medications you are presently taking, including dosage and frequency. Please include non-prescription medications, such as iron, aspirin, antacid, laxatives, including any aspirin like products. ____________________________ ________________________________

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F. Please List Allergies and the reaction they cause, including foods:

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Have you or any blood relative had problems with anesthesia? Yes No
If yes, describe: ____

____

G. Please List all previous hospitalizations (surgery, childbirth, medical illness):

Date (Approximate Year)	Reason	Place (Hospital or City)
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Patient's Name________________________Guardian's Name_________________ Date__________
(If Patient Is a Minor)

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