

MEDICAL HISTORY

Name: _____ Age: _____ Height: _____ Weight: _____

***Update for Repeat Patients**

Please update with any changes since your last visit on _____, if more than 90 days from last visit, please complete entire form. Date

Are there any changes in your history? You must address your current pain level, and any other areas marked with asterisk (*).

- | | Yes | No | | If yes, please explain |
|--------------------------|--------------------------|----|--|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | | Heart attack, angina, irregular heartbeat | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Mitral Valve prolapse / rheumatic fever | _____ |
| | | | Last time an EKG done? _____ | Where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Do you have sleep apnea or use a CPAP? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | High blood pressure | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Epilepsy, seizures, fainting spells | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Paralysis or stroke | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Diabetes | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Thyroid problems | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Asthma, bronchitis, emphysema | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Do you smoke? _____ ppd _____ years | |
| | | | Last chest x-ray date? _____ | Where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Hepatitis, jaundice | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Alcohol consumption? How much? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Reflux, heartburn | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Kidney or bladder problems | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Neck or back trouble | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Arthritis | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Bleeding tendency or clotting problems | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Could you possibly be pregnant? LMP | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | | Any other medical problems not listed | _____ |

* Are you taking any medications, Rx diet pills, herbs, vitamins? _____

* Are you allergic to any medications, fish, eggs, soy products, latex? Please list: _____

Previous surgeries _____

Problems with anesthesia _____

Family history problems with anesthesia _____

Dentures, partial plates, caps, crowns, bridges, braces? _____

Blood tests done in the last month? Where? _____

Do you have any body piercing? Where? _____

* Do you have any pain at the surgical, injection and/or procedure site? _____

IF YES: Specific location and level: _____

Onset: _____ Pain intensity on scale: _____ Acceptable level: _____

Frequency: _____



Check all that apply:
Quality: Sharp _____ Constant _____ Aching _____ Intermittent _____ Pressure/Tightness _____
Sensation: Normal _____ Decreased _____

What, if any, medication do you take for pain relief? _____

Last dose taken? _____

Is your pain satisfactorily controlled now? _____

Reviewed by: _____ R.N. Patient: _____