Patient Name____ **Today's Date**______________
Home Address____ **Date of Birth**_______________
____

Do you have an Advance Directive? Yes or NO

Patient Medical History

Physician_______________________ Office Phone ________________ Last exam______________

1. Are you under medical treatment now? Yes or NO
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes or NO
3. Are you taking any medication(s) including non-prescription medication? Yes or NO If yes, please provide us with a list of medications.____
____
4. Does your child have a mental or physical disability? Yes or NO
5. Do you use tobacco? Yes or NO
6. Do you use Alcohol, cocaine or other drugs? Yes or NO
7. **Are you allergic to or have you had any reactions to the following? Please circle YES or NO for each:**

Yes/no *Local anesthetics* **yes/no** *Barbiturates* **yes/no** *Aspirin*
Yes/no *Penicillin or other antibiotics* **yes/no** *Sedatives* **yes/no** *Latex*
Yes/no *Sulfa Drugs* **Other:**______________________________________

7. **Do you have or have you had any of the following? Please circle YES or NO for each of the conditions listed below:**

Yes/No *High Blood Pressure* **Yes/No** *Heart Disease* **Yes/No** *Chest Pains* **Yes/No** *Stroke*

Yes/No *Low Blood Pressure* **Yes/No** *Cardiac Pacemaker* **Yes/No** *Easily Winded* **Yes/No** *Tuberculosis*

Yes/No *Fainting/Seizures* **Yes/No** *Angina* **Yes/No** *Asthma* **Yes/No** *Emphysema*

Yes/No *Anemia* **Yes/No** *Diabetes* **Yes/No** *Kidney Disease* **Yes/No** *Glaucoma*

Yes/No *AIDS/HIV infection* **Yes/No** *Leukemia* **Yes/No** *Cancer* **Yes/No** *Arthritis*

Yes/No *Hepatitis/Jaundice* **Yes/No** *STD* **Yes/No** *Liver Disease* **Yes/No** *Heart Trouble*

Yes/No *Respiratory Problems* **Yes/No** *Radiation Therapy* **Yes/No** *Recent Weight Loss* **Yes/No** *Heart Murmur*

Yes/No *Epilepsy/Convulsions* **Yes/No** *Hay fever/Allergies* **yes/no** *swollen ankles*

Yes/No *Total Joint replacement*: **Yr**_____________ **and what body part**_______________________________

8. Women Only:
   a) Are you pregnant or think you may be pregnant? Yes or NO
   b) Are you nursing? Yes or NO
   c) Are you taking birth control pills? Yes or NO
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes or No
10. Have you ever had or have any of the following conditions:

_________Prosthetic cardiac valve
__________Prior incidence of Infective Endocarditis
__________Heart transplant in which cardiac valvulopathy has developed
__________Congenital heart disease (CHD) are only required prophylaxis with one of following conditions
______1. unrepaired cyanotic CHD, including palliative shunts and conduits
______2. CHD repaired by prosthetic material or device less than 6 mos ago
______3. or a residual defects after repair (inhibiting endothelialization)
__________Total Joint Replacement

I Certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature_____________________________________ Date: _________________________________
Patient, Parent or Guardian

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