PATIENT HISTORY

NAME: _____ RACE: _____
ETHNICITY: Hispanic / Non-Hispanic (circle one)
PRIMARY LANGUAGE SPOKEN: _____
PERSON ABLE TO TRANSLATE (IF NECESSARY):

_____
Name Phone Number

HEIGHT:_____ WEIGHT:_____

Please circle YES or NO for each question, sign your name and fill in the date at the end of the form.

1. Have you ever taken, or are you currently taking Flomax (Tamsulosin)	Yes	No
2. Are you currently taking Cardura (Doxazosin), Hytrin (Terazosin), Uroxatral (Alfuzosin), or Minipress (Prazosin)?	Yes	No
3. Do you have an irregular heartbeat or any trouble with your heart?	Yes	No
4. Do you have high blood pressure?	Yes	No
5. Have you ever had a stroke / TIA (Transient Ischemic Attacks)? If yes, when _____	Yes	No
6. Do you have asthma, emphysema (COPD), or Sleep Apnea? (Circle)	Yes	No
7. Have you ever had a heart attack? If yes, when _____	Yes	No
8. Any history of epilepsy or seizures?	Yes	No
9. Have you had rheumatic fever?	Yes	No
10. Are you a diabetic? If yes, list type and amount of drug taken for diabetes _____	Yes	No
11. Do you smoke or use tobacco? If yes, how much?_____	Yes	No
12. Have you received a Pneumonia vaccination?	Yes	No
13. Have you received an Influenza vaccine (Flu shot) this season?	Yes	No
14. Do you have multiple sclerosis?	Yes	No
15. Have you had a persistent cough for over 3 weeks?	Yes	No
A. Is there blood in the sputum?	Yes	No
B. Any elevated temperature (over 100°F in the last week?)	Yes	No
C. Are you having night sweats?	Yes	No
D. Any recent unexplained weight loss? (5% in the last 3 months)	Yes	No
E. Any known contact with TB, or have you been diagnosed with TB?	Yes	No
16. Have you ever been diagnosed with cancer? If yes, type of cancer_____	Yes	No
17. Do you have false teeth, caps or contact lenses? (Circle all that apply)	Yes	No
18. Have you ever had jaundice or hepatitis?	Yes	No
19. Have you ever been tested for HIV (AIDS)? If yes, when and what were the results?_____	Yes	No
20. Have you ever had any problems with mental illness?	Yes	No

—Over—

21. Have you ever been told you are a bleeder? Yes No

22. Do you have frequent headaches or migraines? Yes No

23. Have you ever had a head injury or brain tumor (circle) Yes No

24. Have you ever lost consciousness? Yes No

25. Do you use alcohol? If so, frequency: _____ Yes No

26. Do you use pain medication with narcotics? Yes No

27. Do you use recreational drugs? Yes No

28. Have you ever had a blood transfusion? Yes No
If so, when:_____ where _____

29. Have you ever had general anesthesia? Yes No
If so, date of the last time: _____

30. Have you ever had a reaction to local or general anesthesia Yes No
If yes, what kind of reaction:_____

31. Please list all of the operations you have had. Give dates (Month/Year)

_____

_____

32. Any family history of anesthetic problems, including sudden death or malignant hyperthermia (an unusually increased temperature after anesthesia)? Yes No

33. Have you ever had any of the following problems? If yes, please mark.

☐ Glaucoma	☐ Blindness	☐ Cataract	☐ Lazy eye
☐ Retinal Disease	☐ Crossed Eyes	☐ Macular Degeneration	
☐ Retinitis Pegmentosa		☐ Cranial or Temporal Arteritis	
☐ Serious Eye injury	☐ Optic Neuritis	☐ Keratoconus	

34. Family History	Living		General Health	Cause of Death
Mother	Yes	No	_____	_____
Father	Yes	No	_____	_____
Brother(s)	Yes	No	_____	_____
Sister (s)	Yes	No	_____	_____

35. If you have any medical problems not covered by the above questions - such as... thyroid problems, cholesterol problems, fibromyalgia, etc. please note:

_____

_____

SIGNATURE:_____ **DATE:**_____