MEDICAL HISTORY

Have you ever been treated or are being treated for any of the following?
Please check ALL that apply:

__ Anesthesia Problems
__ Asthma
__ Bleeding Tendencies
__ Cancer
__ Colitis/ Bowel Problems
__ Diabetes
__ Heart Issues/ High Blood pressure
__ Hepatitis/ Jaundice
__ Hernia
__ Kidney/ Bladder/ Prostate Problems
__ Pregnancy
__ Stroke
__ Thyroid Problems

Other_____

Surgical History

Please, list surgeries you have had in the past:

Surgery	When	Where

I confirm that the information provided is accurate and complete to the best of my knowledge

X_____ Date_____
patient/ responsible party

Revised: 04/30/2020