MEDICAL HISTORY

Patient's Name: Date of Birth: / / Height: Weight:

Street Address: City: State: Zip:

Responsible Party's Name: Relationship to patient:

Phone: Cell Home: Work:

Has the patient ever had any of the following?

1. Heart Conditions (congenital defects, shortness of breath, pacemaker, murmur, high blood pressure) If yes, please explain:________________	Yes ❑ No ❑
2. Blood conditions (anemia, easy bruising/bleeding, hemophilia, frequent nose bleeds, anemia, poor clotting, sickle cell, HIV) If yes, please explain:________________	Yes ❑ No ❑
3. Lung conditions: (emphysema, shortness of breath, TB, asthma, recent cold or flu, RSV) If yes, please explain:________________	Yes ❑ No ❑
4. Digestive tract or abdominal conditions (stomach ulcers, reflux, nausea, difficulty swallowing): If yes, please explain: ________________	Yes ❑ No ❑
5. Infectious conditions: (AIDS, hepatitis, herpes/cold sores) If yes, please explain: ________________	Yes ❑ No ❑
6. Endocrine conditions (thyroid, parathyroid disease or calcium deficiency, diabetes) If yes, please explain:________________	Yes ❑ No ❑
7. Autoimmune Conditions: (rheumatoid arthritis, lupus) If yes, please explain:________________	Yes ❑ No ❑
8. Neurological conditions (epilepsy, seizures, autism, ADHD, stroke) If yes, please explain:	Yes ❑ No ❑
9. Muscular problems (weakness, paralysis, muscular dystrophy) If yes, please explain	Yes ❑ No ❑
10. Congenital disabilities or syndromes, like Trisomy 21 (Down Syndrome): If yes, please explain:	Yes ❑ No ❑
11. Kidney Problems: (kidney failure)	Yes ❑ No ❑
12. Has the patient or any blood relatives ever had problems with general anesthesia?	Yes ❑ No ❑
Please list all serious medical conditions or hospitalizations and dates:	
Please list all surgical operations and dates:	
Please list all allergies (food, medicine, latex, etc):	

I understand that withholding or misrepresenting any information about my health could seriously jeopardize my safety. I have carefully reviewed the above medical health history and answered all questions to the best of my knowledge. I understand it is my responsibility to inform the doctors of Dream Guard Anesthesia of any changes in medical status.

______________________ ______________________

Patient Signature Date