

## Confidential Medical History

### PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Telephone (C) \_\_\_\_\_ (H) \_\_\_\_\_ (O) \_\_\_\_\_  
 Email \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Medical Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
 Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_  
 MCP \_\_\_\_\_ Expiration Date \_\_\_\_\_

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a heart attack, chest pain, angina, or chest tightness?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had heart failure or fluid in your lungs?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a heart murmur or valve problem?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been treated for an irregular heartbeat?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have high blood pressure?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?
<input type="checkbox"/>	<input type="checkbox"/>	Do you cough frequently or have bronchitis or emphysema?
<input type="checkbox"/>	<input type="checkbox"/>	Does climbing one flight of stairs or walking one city block make you short of breath?
<input type="checkbox"/>	<input type="checkbox"/>	Do you now or have you recently smoked cigarettes? If yes, _____ packs per day for _____ years.
<input type="checkbox"/>	<input type="checkbox"/>	Do you have sleep apnea?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have liver disease or a history of jaundice or hepatitis?
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink more than three drinks of alcohol per day? If yes, how many per week? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have indigestion, heartburn, or hiatus hernia?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of thyroid problems?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have diabetes? If yes, <input type="checkbox"/> Diet-Controlled <input type="checkbox"/> On Pills <input type="checkbox"/> On Insulin
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a kidney problem?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have numbness or weakness of your arms or legs?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had epilepsy, blackouts, seizures, or a stroke?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had problems with blood clots or excessive bleeding?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other medical problems? Please list: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a general anesthetic? If yes, when was your last? _____
<input type="checkbox"/>	<input type="checkbox"/>	Has your health changed since your last anesthetic?
<input type="checkbox"/>	<input type="checkbox"/>	Have you or any of your family had a reaction to an anesthetic or the placement of a breathing tube?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have neck or jaw pain or arthritis?
<input type="checkbox"/>	<input type="checkbox"/>	Is there a possibility that you are pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Have you taken prednisone, steroid medication, or cortisone-like drugs in the past year?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken Ozempic or ozempic like medications, either currently or in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Would you refuse a blood transfusion as a life-saving procedure?

Please list any food or medication allergies that you have \_\_\_\_\_

Please list any medications (including herbal supplements) you are taking (name, dosage, how often) \_\_\_\_\_

Please list the operations that you have had in the past \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ (lbs / kg) Height \_\_\_\_\_ (in / cm)

Date \_\_\_\_\_ Patient \_\_\_\_\_

Date \_\_\_\_\_ Attending Doctor \_\_\_\_\_