St. Mark's
SURGICAL CENTER

**PATIENT LABEL**

## Medical History Questionnaire

**IMPORTANT !** Please Print answers and bring this form with you

Last Name: _____ First Name: _____ MI: _____

Age: ____ Height: ___ feet ___ inches Weight: ____

Date: _____ Allergies: _____

Medications: If more room is needed use back of this form

| Name of Medication | Size or Dose? | How Often? |
|---|---|---|
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Last Visit to Primary Care Physician or Cardiologist: _____

| **Previous Surgery/Hospitalizations and year:** | **Any Anesthesia Problems** |
|---|---|
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**Name any Condition you have or had: Circle Yes or No – If yes explain on the back of this form**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. High/Low Blood Pressure | Yes | No | | 11. Thyroid Problems | Yes | No |
| 2. Heart Problems | Yes | No | | 12. Sleep Apnea | Yes | No |
| 3. Lung/Breathing Problems | Yes | No | | 13. Dentures/Partial Plate | Yes | No |
| 4. Neurological Problems | Yes | No | | 14. Caps/Bridges | Yes | No |
| 5. Liver Problems | Yes | No | | 15. Smoker - ___ # per day | Yes | No |
| 6. Kidney Problems | Yes | No | | 16. Alcohol - ___ # drinks daily | Yes | No |
| 7. Acid Reflux Problems | Yes | No | | 17. Pregnant | Yes | No |
| 8. Hiatal Hernia Problems | Yes | No | | 18. Other: _____ | Yes | No |
| 9. Gastrointestinal Problems | Yes | No | | | | |
| 10. Diabetes | Yes | No | | | | |