Botsford Hospital
28050 Grand River Avenue
Farmington Hills, MI 48336-5933

(To be completed by patient)

Patient Medical History Information

PATIENT NAME: ______________________________ SEX: ☐ M ☐ F AGE: ________
Last First Middle Initial

HOME PHONE: (_____)______________________ WORK PHONE: _(_____)______________________

CELLULAR: (_____)______________________

CARDIOLOGIST, HT DOCTOR (if applicable) ______________________ PHONE: (_____)______________

FAMILY PHYSICIAN NAME: ______________________ PHONE: (_____)______________

Circle the phone # where you can be reached the day before your surgery/procedure for your surgical time.

A. Have you ever had any of the following:

	Yes	No		Yes	No		Yes	No
An exam by a cardiologist (heart doctor)			Ultrasound of Heart (Echocardiogram)			Exercise Stress Test		
Heart Catheterization			Pacemaker / ICD					

B. Do you now have or have you ever had any of the following:

	Yes	No		Yes	No		Yes	No
Any Loose or Chipped Teeth Now			Heart Failure/Heart Attack			Rheumatic Fever		
Caps/Bridges/Dentures/ Bonding Root Canal/Crowns			Heart Valve Disorder			Epilepsy/Seizures		
Temporal Mandibular Joint Dis.			Do you take Pre-dental antibiotics			History of Anemia (low blood count)		
Recent Bronchitis or Pneumonia			Stomach Ulcer			Sickle-Cell Anemia/Trait		
History of Asthma			Kidney Disorder			History of Bleeding or Bruising		
Tuberculosis			Thyroid Disorder			Excess Bleeding from Surgery		
Shortness of Breath walking up one flight of stairs			Diabetes			Blood Transfusion		
High Blood Pressure			Liver Disease, Jaundice, Hepatitis			If there is a need for blood products during surgery is your surgeon aware of your personal preference		
Chest Pain			Stroke			Phlebitis/Blood Clots		
Sleep Apnea			Multiple Sclerosis or Polio			Hearing Aid		
Do you snore?			Head Injury			Glasses/Contacts		
Have you gained 10-15 pounds in the last year?			Scoliosis (curvature of the spine)			Do you use any of the following: Cane, Walker, Crutches, Wheelchair		
Do you have excessive daytime sleepiness?			Irregular Heart Beat, Palpitations			Infectious Disease		

C. Do you have any special concerns?

____

____

____

____

D. 1. Do you or have you ever smoked (including pipe / cigars)? ☐ No ☐ Yes
Number of packs / cigars per day ________ Number of years? ________ When was your last cigarette, cigar, pipe? ________

2. Do you drink alcoholic beverages on a weekly basis? ☐ No ☐ Yes, How much? ______________________

3. Do you use street drugs or marijuana? ☐ No ☐ Yes, How often? ___________________________________

4. Are you pregnant? ☐ No ☐ Yes Date of last menstrual period ____________
(On the morning of surgery, please advise your anesthesiologist if there is any possibility you may be pregnant.)

5. Height ____________ Weight ____________

E. Please List **All Medications** you are presently taking, including dosage and frequency. Please include over the counter medications, such as **herbal remedies, diet medication, vitamins and any aspirin products**.

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

F. Please **List Allergies** to medications and the reaction they cause. ____

____
____
____

G. Do you have a latex allergy? ☐ No ☐ Yes If yes, describe: ____

H. Have you or any blood relatives had problems with anesthesia? ☐ No ☐ Yes If yes, describe: __________________

____

I. Please list all previous hospitalizations (surgery, childbirth, medical illness):

Date (approx. year)	Reason	Place (hospital or city)

J. Have you ever been a patient at Botsford Hospital? ☐ No ☐ Yes Last Date: ________________________________

____
Signature of Patient, Parent, or Legal Guardian Today's Date

4-23-07