DR. MUNE GOWDA
MEDICAL HISTORY INFORMATION

PATIENT NAME:____ PATIENT ACCT#:______________________________

AGE:________ HEIGHT:_________ WEIGHT:__________ALLERGIES:____

OCCUPATION (Please describe briefly what your job requires):____

WHEN WAS YOUR LAST PHYSICAL CHECK-UP?______________________ DID IT INCLUDE AN ELECTROCARDIOGRAM?______________ CHEST X-RAY?________________

DO YOU HAVE ANY SERIOUS ILLNESSES? PLEASE LIST:____

DO ANY SERIOUS ILLNESSES RUN IN YOUR FAMILY? PLEAE LIST:____

MEDICATIONS AND DRUGS

WHAT IS YOUR APPROXIMATE DAILY CONSUMPTION OF THE FOLLOWING?:

TABACCO________________ ALCOHOL_________________ DRUGS_______________ ASPRIN, ADVIL OR MOTRIN__________________

ARE YOU ALLERGIC TO ANY MEDICATION? PLEAST LIST:____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:____

REASON FOR VISIT

PLEASE DESCRIBE ILLNESS/INJURY/REASON FOR SEEING THE DOCTOR:____

____DATE OF INJURY:______________________________

PREVIOUS TREATMENT:____

RIGHT-HANDED?____________LEFT-HANDED?____________WERE X-RAYS TAKEN?______________________________

PERTINENT PRE-OPERATIVE INFORMATION

ARE YOU OR COULD YOU BE PREGNANT NOW? ____YES ____NO

HAVE YOU EVER HAD A REACTION TO ANESTHESIA? ____YES ____NO

HAS ANY FAMILY MEMBER HAD A REACTION TO ANESTHESIA? ____YES ____NO

ARE YOU ALLERGIC TO ADHESIVE TAPE? ____YES ____NO

DO YOU HAVE HIGH BLOOD PRESSURE? ____YES ____NO

DO YOU HAVE A HEART MURMUR? ____YES ____NO

HAVE YOU HAD SCARLET FEVER OR RHEUMATIC FEVER? ____YES ____NO

DO YOU BLEED EASILY? ____YES ____NO

DO YOU HAVE LARGE SCARS OR KELOIDS? ____YES ____NO

ARE YOU SHORT OF BREATH WHEN WALKING? ____YES ____NO

HAVE YOU EVER HAD PSYCHIATRIC CARE OR BEEN ADVISED TO SEE A PSYCHIATRIST? ____YES ____NO

PREVIOUS SURGERY AND INJURIES (use reverse side if necessary)

OPERATION	YEAR	HOSPITAL	CITY	SURGEON	ANESTHESIA	COMPLICATIONS
1						
2						
3						
4						

PATIENT'S SIGNATURE (PARENT OR GUARDIAN)____DATE______________________