Hamilton Lake Clinic
Because your life matters

Patient Medical History for Office Surgery

Date of surgery: _____ Surgeon:_____

Name:_____ Date of birth:_____

Primary care physician:_____

Are you on any anti-coagulants:_____ Current weight:_____

Do you have a pacemaker or defibrillator:_____ Height:_____

What other specialists/doctors do you see:_____

Medications you are currently taking (include any over-the-counter meds, herbals, topical, inhalers,eye-drops, vitamins, diet aids and all prescriptions)

_____
_____
_____

List any allergies to medications, iodine/contrast dye, latex, tape or food. Please include the reaction you have:

_____
_____

Check if you have or have ever had any of the following:

o Heart Failure	o Stroke	o Glasses
o High Blood Pressure	o Weakness	o Contacts
o MI/Heart Attack	o Alzheimer's	o Hearing Aid
o Pacemaker	o Dementia	o Immune Deficiency
o Defibrillator	o Prosthetic Joint	o Tuberculosis
o Heart/Cardiac Valve	o Bleeding Tendencies	o Hepatitis
o Mitral Valve Insufficiency	o Use a cane/walker/wheelchair	
o Diabetes Type I or II o Use Insulin		

Do you take an antibiotic for medical procedures or dental work? o Yes o No

Will anyone be coming with you? o Yes o No

Patient Signature _____ Dr Signature _____