Drs. Oghalai, Krutoy and Toscano **Medical History** **Patient ID#:**

Patient Name:		**Medical Doctor**	**Phone Number**
Height	**Weight**		

Medications (including Over the Counter / Herbal Supplements) ☐ **See Attached List**

Medication	**Dose**	**Frequency**	**Medication**	**Dose**	**Frequency**
1.			4		
2.			5.		
3.			6.		

Have You Had or Do You Currently Have	**✓ Y**	**✓ N**	**Notes**	**Have You Had or Do You Currently Have**	**✓ Y**	**✓ N**	**Notes**
Abnormal Heart Condition				**History of Alcohol Abuse**			
Asthma				**History of Drug Use (including Marijuana)**			
Bleeding Condition/ Blood Thinners				**Joint Replacement (i.e. Hip / Knee)**			
Cardiac Pacemaker				**Kidney Disease**			
Chemotherapy or IV Drug Treatment: (i.e. Aredia, Bonefos, Zometa) (for cancer: Breast, Prostate, or Multiple Myeloma				**Osteoporosis Medicine: Actonel/Risedronate; Didronel Boniva/Ibandronic Acid Fosamax/Alendronate Prolia/Denosumab Reclast-Zometa/Zolendronic Acid Skelid/Tiludronate Disodium**			
COPD (Emphysema / Chronic Bronchitis)				**Liver Disease**			
Damaged Heart Valves (i.e. Mitral Valve Proplase)				**Radiation (other than x-rays/radiographs)**			
Depression				**Rheumatic Fever**			
Diabetes				**Sleep Apnea**			
Epilepsy				**Smoke / Use Tobacco / Vape**			
Fainting or Black Out Spells							
Heart Disease / Attack / and/or Surgery				**INFECTIOUS DISEASES**			
Heart Murmur				**Hepatitis**			
High Blood Pressure				**HIV (Aids Virus)**			
Stroke (or TIA)				**Tuberculosis**			

Allergies

Drug Allergies	**Y**	**N**	**Notes**	**Drug Allergies**	**Y**	**N**	**Notes**
Clindamycin				**Oxycodone**			
Codeine				**Penicillin**			
Erythromycin				**Amoxicillin**			
Hydrocodone				**Sulfa**			
Latex				**Egg, Soy, Peanuts**			
Local Anesthetic				**Other**			
				Other			

Women Only

1-Are you currently taking Birth Control? ____ Y ____ N **2-**Are you Currently Pregnant? ___Y ___N (How Far Along? _____)
3-Are you currently nursing? ___Y ___N ***(Please note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician and/or gynecologist for assistance regarding additional methods of birth control.)***

Past Surgical History		**Additional Comments / Information**
1.	**4.**	
2.	**5.**	
3.	**6.**	

By signing below, I acknowledge that I have read and answered the questions above to the best of my knowledge. I will not hold my surgeon or any other member of his staff responsible for errors or omissions that I have made in the completion of this form.

Patient (Guarantor Signature if under 18)	**Date**	**Staff Initials**
X		