

Patient Medical History Form

Patient Name

For office use: Bradma label

Occupation

Height

Weight

Medical History

- High Blood Pressure
- Heart Condition
- Diabetes
- Respiratory Condition
- Kidney Disease

Other:

Allergies:

Current Medications

Please list your current medications (dose not necessary) or include a list of medications from your pharmacist.

Do you take blood thinners? No Yes

Do you have Sleep Apnea? No Yes Do you use a CPAP machine? No Yes

Please list all previous surgeries:

Do you smoke? No Yes Quantity per day

Do you drink alcohol? No Yes Quantity per day

Do you use recreational drugs? No Yes Quantity per day