The Dallas Limb
Restoration Center

Medical History Questionnaire

Patient Name _____ DOB _____ Today's Date _____

Primary Care Provider _____ Height _____ Weight _____

Why are you here today? _____

Patient's Past Surgical History List all surgeries including dental, cosmetic, and elective procedures.

Name of Surgery	Year	Name of Surgery	Year

Have you ever had general anesthesia? ☐ No ☐ Yes Have you ever had conscious sedation? ☐ No ☐ Yes
Have you ever had any problems with any anesthesia or conscious sedation? ☐ No ☐ Yes, describe _____

Family History: Check mark if anyone in your immediate family had or has any of the following disease? If deceased, what age and disease.

	Cancer	Diabetes	Heart Disease	High Blood Pressure	Stroke	Deceased, what age and disease
Mother						
Father						
Maternal Grandfather						
Maternal Grandmother						
Paternal Grandfather						
Paternal Grandmother						
Sibling						
Sibling						

Social History Please check all that apply.
Marital Status: ☐ Single ☐ Married ☐ Other **Stressors:** ☐ Home ☐ Work ☐ Relationship
Employment: ☐ Unemployed ☐ Disabled ☐ Retired ☐ Domestic Engineer/Homemaker ☐ Student ☐ Employed
Substance Abuse / Recreation Drugs: ☐ Denies ☐ Yes, what type: _____ last used _____
Alcohol Consumption: ☐ Denies ☐ Yes: Daily ☐ 1-2 drinks/week ☐ 1-2 drinks/month ☐ 1-2 drinks/year
Smoking / Tobacco: ☐ Denies ☐ Yes _____ packs/day for _____ years ☐ Quit: When _____ ☐ Chew ☐ Dip
Immunizations: ☐ TD less than 10 years ☐ Pneumococcal less than 5 years ☐ Childhood immunization up to date

MEDICATION ALLERGIES:

Medication Name	Reaction	Medication Name	Reaction

CURRENT MEDICATIONS: List all prescription, over the counter, herbal, and vitamins you take.

Name and Dosage	Name and Dosage	Name and Dosage

Signature of Patient _____ Date _____

Name of Person Completing Form: _____ Relation to Patient _____