

MEDICAL/SURGICAL HISTORY

Patient Name: _____

Today's Date: _____

Patient No.: _____

Surgeon Name: _____

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we can safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age: _____ Height: _____ Weight: _____ Occupation: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

Medication(s):	Amount	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all drug allergies: _____

Have you ever used (check any that apply)? LSD Cocaine Marijuana None

Are you a (check one): Smoker Ex-Smoker Non-Smoker

If you are/were a smoker, how much are/were you smoking? _____ How Long? _____ Quit how long ago? _____

How much alcohol do you drink? _____ Type? _____

Family History Has any blood relative ever had the following:

	No	Yes		No	Yes		No	Yes
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

Past Medical History Have you ever had the following:

	No	Yes		No	Yes		No	Yes
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			

Review of systems Do you have now or have had within the past year:

	No	Yes		No	Yes		No	Yes
Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	Joint or Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>			

Is there any possibility that you may be pregnant at this time? Yes No

List all surgeries that you have had (include plastic surgery) or major illnesses with dates:

Surgery / Illness	Date
_____	_____
_____	_____
_____	_____

Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers)? Yes No

Have you ever seen a cardiologist? Yes No

Physician Name: _____

Date of last EKG: _____

I verify that the above information is true and accurate to the best of my knowledge.

Signature of patient or parent if minor _____

Date _____