Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visit Type: (Please Circle One) New Patient Hospital Follow-up Established (Follow-Up Care)

**Medical History**: (Please Circle All That Applies)

Heart Disease Heart Attack Heart Problems Stroke High Blood Pressure High Cholesterol

Diabetes Asthma COPD Seizures Liver Disease Hepatitis C Hepatitis B Acid Reflex

Back Pain Thyroid Problems Liver Disease Fibromyalgia Migraines Anxiety Depression Kidney Disease

Cancer (List Type):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:** (If Applicable, Please list along with year)

**Has patient ever had any problems with anesthesia from previous surgeries?** Yes or No If ‘Yes’ Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Name of Surgery/Procedure** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |

**Hospitalizations: Has patient been hospitalized in the last 90days**? Yes or No If ‘yes’ please

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: (Please Circle If Applicable)

No Known Allergies Sulfa Penicillin Cholesterol Medications (statins) Codeine Latex

Other Allergies**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**  (Please Circle, If Applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| **Social History** | **Currently Use** | **Type/Amount/Frequency** | **If stopped, When?**  **(Year)** |
| **Tobacco Use?** | Yes No |  |  |
| **Alcohol Use?** | Yes No |  |  |
| **Recreational Drugs?** | Yes No |  |  |

**Family History:** (Please check all that apply)

Problem Mother Father Grandparents (Mat. Or Pat.) Bro/Sister

Hypertension **\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_

Heart Disease \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Abnormal Cholesterol \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Liver Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer (List Type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Mother: Living or Deceased

Patient’s Father: Living or Deceased

**Current Medications:**

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Strength** | **Frequency (How often taken)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Blood Thinners:** Is the patient on any blood thinner medication (Plavix, Xarelto, Warfarin, Etc.) Yes or No If ‘Yes’ please list below.

**Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescribing Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date