|  |
| --- |
| **Patient Name:** |
| DOB: | Age: | Marital Status: | **Weight lb** |
| **What surgery are you considering?** |   |   | **Height ft in** |
| **General Information:** | **YES** | **NO** | **Comments:** |
|  **1. HEART** |   |   |   |
|  High Blood Pressure |   |   |   |
|  Heart Attack |   |   |   |
|  Chest Pain |   |   |   |
|  Irregular Heart Beat |   |   |   |
|  High Cholesterol |   |   |   |
|  Family history of heart disease |   |   | Which family members? |
|  **2. LUNGS** |   |   |   |
|  Sleep Apnea |   |   |   |
|  Asthma |   |   |   |
|  Wear oxygen during day/night? |   |   |   |
|  Family history of lung problems? |   |   | Which family members? |
|  **3. KIDNEY** |   |   |   |
|  Urinary tract Infection  |   |   |   |
|  Kidney Stones |   |   |   |
|  **4. DIGESTIVE TRACT** |   |   |   |
|  Ulcers |   |   |   |
|  Reflux/Heartburn |   |   |   |
|  Hepatitis |   |   |   |
|  Pancreatitis |   |   |   |
|  **5. MUSCLE/BONE** |   |   |   |
|  Arthritis |   |   |   |
|  Muscle weakness |   |   |   |
|  **6. NEUROLOGICAL/PSYCH** |   |   |   |
|  Head injury/Stroke  |   |   |   |
|  Seizures |   |   |   |
|  Depression |   |   |   |
|  Headaches |   |   |   |
|  **7. BLEEDING** |   |   |   |
|  Anemia |   |   |   |
|  Bleeding/Clotting problems |   |   |   |
|  Family history of bleeding problems? |   |   | Which family members? |
|  **8. METABOLIC** |   |   |   |
|  Diabetes |   |   |   |
|  Thyroid Problems |   |   |   |
|  **9. BREAST** |   |   |   |
|  Personal history of breast masses/problems? |   |   |   |
|  Family history of breast cancer? |   |   | Which family members? |
| 1. Please list **ALL CURRENT MEDICATIONS**, including birth control pills, hormones and vitamins, herbal medication, diuretics and weight loss drugs. **Include over-the-counter medications.**  |
| **Medication Name** | **Dose** | **Frequency** | **How Long?** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

**ALLERGIES:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2. Do you have any MEDICATION ALLERGIES? |

|  |
| --- |
|  |

 | Yes |

|  |
| --- |
|  |

 | No |  | Which?  |

|  |
| --- |
|  |

 |

|  |
| --- |
| 3. Have you, or any member of your family, ever had any difficulties with any medications, drugs or gases used for anesthesia? Yes No If yes, when and where? |

**SOCIAL HISTORY:**

|  |
| --- |
| 4. Do you have cocktails regularly or consume regular amounts of alcoholic beverages, including beer, wine or other alcohol? |
|  Yes No If so, how much?  |
| 5. Do you smoke? Yes No If so, how much? For how long?   |
|  Do you vape? Yes No If so, how much? For how long?  |
|  Use nicotine patches? Yes No If so, how much? For how long?  |
| 6. Are you pregnant? Yes No  |
| 7. How many pregnancies? Births? Breast Fed? Yes No Recently? |

**RECENT MEDICAL HISTORY:**

|  |
| --- |
| 8. Who is your personal physician, if any? Please list all physicians presently caring for you. |
|  |

|  |
| --- |
| 9. Have you ever been under psychiatric care? Yes No When? Why?  |

|  |
| --- |
| 10. Is there anything else you think the doctor should know? |
| 11. **Please list all SURGERIES AND HOSPITALIZATIONS**, including procedures done for cosmetic reasons:  |

|  |  |  |
| --- | --- | --- |
| **SURGERIES** | **When?** | **Why?** |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

**By signing below, I agree that the above information is complete and accurate to the best of my knowledge.**

**Signature: Date:**