|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:**