

HEALTH and MEDICAL HISTORY

Name _____ Date _____

Purpose of visit/procedure _____

Have you seen other surgeons for the same problem that brings you here today? Y N Name of surgeon: _____

Do you have a personal physician? Y N Physicians Name: _____ Address: _____ Phone # () _____

Are you being treated for any medical condition at this time? Y N If yes, please explain: _____

List any past medical problems: _____

List all operations in the past: _____

Have you been treated for psychological problems like depression? Y N If yes, please explain: _____

List all current medications: _____

List medications you have taken in the last year: _____

Do you smoke or use tobacco in any form Y N Do you form large scars keloids? Y N

Do you drink alcoholic beverages? Y N Are you pregnant? Week # _____ unsure Y N

Do you have frequent boils or infections? Y N Do you bleed easily from cuts or surgery? _____

Please list any allergies: _____

Do you have any allergies/reactions to anesthesia? Y N If yes, please explain _____

Do you now or have you had any of the following within the past 18 months? (Circle "yes" or "no" and leave blank if uncertain)

Changes in appetite	Y N	Blurred Vision	Y N	Backaches	Y N
Depression	Y N	Do you wear contacts or glasses	Y N	Enlarged Veins	Y N
Dizziness or fainting spells	Y N	Double vision	Y N	Joint pains & stiffness	Y N
Lack of sex drive	Y N	Eye pain	Y N	Leg cramps walking or at night	Y N
Lump or discharge from breast	Y N	Infected eye	Y N	Muscle cramps or spasms	Y N
Memory loss	Y N	Discharge from ears	Y N	Poor Coordination	Y N
Night sweats or hot flashes	Y N	Ear pain	Y N	Swelling of hands, feet, or ankles	Y N
Paralysis	Y N	Ringling in ears	Y N	Swollen joints	Y N
Persistent fever	Y N	Frequent colds	Y N		
Purple fingers or lips	Y N	Frequent nose bleeds	Y N	Please explain any "yes" answer:	
Recent weight changes	Y N	Loss of smell	Y N	_____	
Seizures	Y N	Sinus trouble	Y N	_____	
Sensitivity to cold or heat	Y N	Persistent hoarseness	Y N	_____	
Sleeplessness	Y N	Sore throat	Y N	_____	
Tire easily or weakness	Y N	Sore tongue or gums	Y N	_____	
Chest pain or discomfort	Y N	Changes to nails or hair	Y N	_____	
Chronic or frequent cough	Y N	Easy bleeding or bruising	Y N	_____	
Difficulty in breathing	Y N	Hives or allergy	Y N	_____	
Palpitations or fluttering of heart	Y N	Skin eruptions	Y N	_____	
Shortness of breath	Y N	Skin rash	Y N	_____	
Spitting blood	Y N	Skin trouble or changes	_____	_____	
Spitting phlegm	Y N			_____	
Wheezing	Y N			_____	

Do you or have you experienced the following?

Alcohol abuse	Y N	Chicken Pox	Y N	Heart disease	Y N	Low blood pressure	Y N	Scarlet fever	Y N
Anemia	Y N	Colitis	Y N	Hemophilia	Y N	Lupus	Y N	Shingles	Y N
Arthritis	Y N	Diabetes	Y N	Hepatitis	Y N	Measles	Y N	Sickle cell disease	Y N
Artificial bones/joints	Y N	Diphtheria	Y N	Herpes	Y N	Migraine headaches	Y N	Small Pox	Y N
Artificial valves	Y N	Drug Abuse	Y N	Hernia	Y N	Mitral valve prolapse	Y N	Stroke	Y N
Asthma	Y N	Emphysema	Y N	High blood pressure	Y N	Mumps	Y N	Thyroid problems	Y N
Bladder infections	Y N	Epilepsy	Y N	HIV+/Aids	Y N	Pacemaker	Y N	Tonsillitis	Y N
Blood transfusion	Y N	Fever blisters	Y N	Hives or eczema	Y N	Pneumonia	Y N	Tuberculosis (TB)	Y N
Bronchitis	Y N	Glaucoma	Y N	Infectious mono	Y N	Polio	Y N	Ulcers	Y N
Cancer	Y N	Hay fever	Y N	Kidney Problems	Y N	Psychiatric treatment	Y N	Venereal disease	Y N
Chemotherapy	Y N	Headaches	Y N	Liver problems	Y N	Radiation treatment	Y N	Whooping cough	Y N
Congenital heart defect	Y N					Rheumatic fever	Y N		

Please explain any "yes" answers: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____