

# MEDICAL/SURGICAL HISTORY

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

What procedures are you interested in?

Are you in good health? YES/NO      If NC, give reason:

Age:      Height:      Weight:

List all medications which you are/or have taken in the last 6 months (prescription and non-prescription). (Especially Aspirin).

Medication(s):	Amount	Frequency
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Do you take herbal supplements (especially Gingko, Ginger, Garlic, St. John's Wort)?

Do you take vitamins (especially C, E, Fish oils)?

List all drug allergies:

Are you a smoker? YES/NO      If YES, how much?      How long?      Quit how long ago?

How much alcohol do you drink?      Caffeine?

Have you had the following?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain            | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disorder       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever       | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Palpitations          | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath   | <input type="checkbox"/> Yes <input type="checkbox"/> No Problems with Scarring |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No Emotional Problems     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Disease            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia                | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Itching            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes              | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Burning            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer                | <input type="checkbox"/> Yes <input type="checkbox"/> No Dryness of Eyes        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorders     |

Is there any possibility that you may be pregnant at this time? YES/NO

List all surgeries that you have had (include plastic surgery):      Date:

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

Do you have (circle): loose or chipped teeth/caps/dentures/contact lenses/None

Patient's Signature: \_\_\_\_\_

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

## Note:

Please stop aspirin products and other blood thinners 2 weeks prior to surgery or discuss with the doctor.