To Our Patients:

You are scheduled for a history and physical (H&P) examination on _____ at _____ with _____.
Please complete this ENTIRE form and bring it with you to your scheduled appointment. This is used to up date your medical history and reduce the risks of complications from surgery and anesthesia.

Thank you for your assistance.

Your name:_____

Place of Surgery:_____
Date of Surgery:_____

Surgeon: _____

PAST MEDICAL HISTORY (please list year each issue occurred)
Any unusual childhood illnesses:

_____
_____

Past hospitalizations and surgeries:

_____
_____

Medical Problems:

_____
_____

If you are female, what was the date of your last menstrual period?

_____

CURRENT MEDICATIONS (please list both prescription and non-prescription)

_____
_____

MEDICATIONS (CONTINUED)

_____
_____
_____

MEDICATION ALLERGIES (including type of reaction)

_____
_____
_____

Any history of Latex sensitivity or allergy: yes___no___

SOCIAL HISTORY

Marital status: married___ single___ divorced___ widow___
Do you have children? yes___ no ___
If yes, what are their names and ages:

_____
_____
_____
_____

Your occupation: _____
Last year of school completed: _____
Tobacco use: yes___ no___
If yes how many packs per day ____
Do you use chewing tobacco? yes___no___
Alcohol use:
How many days per week do you typically drink alcohol? _____
How many alcohol drinks per week will you usually have? _____
Any other drug use? _____
Any concerns about sexuality or sexual function? _____

FAMILY HISTORY

Please list any illness in your family members including heart disease, stroke, diabetes, cancer, high blood pressure, high cholesterol levels, lung disease, liver or kidney disease, depression or suicide.

Father:_____

Mother:_____

Brothers or sisters: _____

Children: _____

Grandparents: _____

DO YOU OR ANYONE IN YOUR FAMILY HAVE BAD REACTIONS TO ANESTHESIA? Yes___ No___

If yes please explain:_____

DO YOU OR ANYONE IN YOUR FAMILY HAVE BLEEDING PROBLEMS?

Yes ___ No ___

If yes please explain: _____

PLEASE CHECK ANY PROBLEMS LISTED BELOW THAT YOU HAVE HAD AND NOTE ANY DETAILS INCLUDING WHEN THIS OCCURRED.

___ FEMALES: last menstrual period _____

___ Fever, chills, night sweats

___ Headaches, head injuries, concussion

___ Eye problems (wear contacts or glasses?)

___ Loose or capped teeth?

___ Cold or allergy symptoms

___ Ear problems, hearing loss, ringing, pain

___ Thyroid problems or x-ray treatment to neck or chest

___ Breast masses, breast discharge, breast pain

___ Breathing problems, shortness of breath, asthma, bronchitis, pneumonia, emphysema

___ High blood pressure, chest pain, palpitations or skipped beats, heart murmur

___ Heartburn, ulcers, gallstones, bowel changes, bloody or black bowel movements, abdominal pain

___ Kidney or bladder infection, leaking urine, pain with urination, kidney stones

___ Muscle pain, joint pain or swelling, broken bones, dislocations, muscle weakness

___ Seizure, loss of coordination, tremors, speech problems, memory loss, numbness, tingling

___ Skin changes, mole change, skin infections, hair loss, psoriasis

___ Abnormal bleeding from any site, clotting problems, bruising easily, transfusion

If yes to transfusions, what year was this done and why? _____

___ Depression, poor sleeping, appetite problems, panic attacks, suicidal thoughts or attempts

PLEASE BRING ANY IMMUNIZATION DATES FOR TETANUS, PNEUMOVAX OR RECENT FLU SHOTS IF YOU HAVE THESE RECORDS.

PREOPERATIVE CLEARANCE MAY REQUIRE: LABS, XRAYS OR EKGs. WE WILL ALSO DO OUR BEST TO UPDATE ALL RECOMMENDED HEALTH MAINTENANCE ITEMS AT THE TIME OF THIS VISIT OR, IF TIME IS LIMITED, WE WILL SCHEDULE THESE BEFORE YOU LEAVE.