Patient Name:_____Date of Birth:_____

SECTION I: May be completed by patient or significant other Date/Time:_____

☐ Patient ☐ Other_____Phone No._____
(Name/Relationship)

Who can we contact in case of emergency?_____
(Name) (Relationship) (Phone)

Surgical Complaint(s): 1)_____2)_____3)_____

PATIENT HISTORY: Do you have or have you ever had? (Check any that apply.) Explain any YES answer below.

	YES	NO		YES	NO		YES	NO
Hearing Problems	☐	☐	Asthma/Chronic Bronchitis/Emphysema	☐	☐	Dizziness/Blackouts/Fainting	☐	☐
Vision Problems	☐	☐	Blood Transfusion	☐	☐	Psychiatric Care/Counseling	☐	☐
Fractures/Dislocations	☐	☐	Exposure to Occupational Hazards	☐	☐	Hepatitis/Jaundice	☐	☐
Arthritis/Back/Neck Problems	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐
Heart Problems/Chest Pain	☐	☐	Thyroid Problems	☐	☐	Cancer/Chemo/Radiation Therapy	☐	☐
Heart murmur	☐	☐	Gastrointestinal problems/Ulcer	☐	☐	Anesthesia Complications	☐	☐
Ankle/Leg Swelling	☐	☐	Rectal Bleeding	☐	☐	Bleeding Disorders/Anemia	☐	☐
Blood Pressure Problems (high/low)	☐	☐	Kidney/Urinary Problems	☐	☐	Other_____	☐	☐
Poor Circulation Arms/Legs	☐	☐	Stroke/Seizures/Severe Headaches	☐	☐	Any chance you may be pregnant?	☐	☐

Date of Last Episode	Frequency / Symptoms	Treatments

Previous hospitalization/surgery/illness (List most recent first.) ☐ None

Date	Reason	Hospital

FAMILY HISTORY:

Diabetes ☐ No ☐ Yes Asthma ☐ No ☐ Yes Heart Disease ☐ No ☐ Yes Cancer ☐ No ☐ Yes High Blood Pressure ☐ No ☐ Yes

Do you have any allergies? ☐ No ☐ Yes (If YES, explain reaction below.):

☐ Food_____

☐ Medications_____

☐ Latex (Rubber)_____

☐ Dyes/Contrast Media_____

☐ Other_____

PLEASE ANSWER THE FOLLOWING:

Do you smoke? ☐ No ☐ Yes Cigarettes/Pipe/Cigar Amount/Day_____# of Years_____(Quit Date)_____

Do you drink alcohol? ☐ No ☐ Yes Type_____ Amount/Day_____# of Years_____(Quit Date)_____

Use recreational drugs? ☐ No ☐ Yes Type_____ Amount/Day_____# of Years_____(Quit Date)_____

SECTION II: MEDICATIONS- Include non-prescription drugs, inhalers, contraceptives, supplements you are currently taking.

Drug	Dose	How Often	Reason for taking	Check if currently using	✔	Last Dose

Medications brought from home? ☐ No ☐ Yes