Today's Date _____ **PATIENT MEDICAL HISTORY**

NAME _____

DATE OF BIRTH _____

Reason for surgical referral: _____

When did this problem start? _____

Surgical History: List all previous operations and approximate dates:

OPERATION	APPROX. DATE	OPERATION	APPROX. DATE

List active medical illnesses for which you are taking medication or being treated:

ILLNESS	ILLNESS

Current medications: Please list **ALL** prescription and non-prescription drugs (including injections, inhalers, eye drops, insulins, and "street" drugs) that you routinely or occasionally have used in the past 30 days:

MEDICATION NAME	DOSAGE	HOW OFTEN	LAST DOSE

Please list and explain all your **ALLERGIES** or sensitivities to medications, foods or other substances.

Name of Medication	Describe Reaction

Recent symptoms or past medical problems:

	Yes	No
1. Current fevers or chills	☐	☐
2. Weight loss	☐	☐
3. Fatigue/exhaustion	☐	☐
4. Cancer history	☐	☐
5. Recent vision changes	☐	☐
6. Glaucoma	☐	☐
7. Sore throat	☐	☐
8. Sinus pain/infections	☐	☐
9. Chest pain (angina)	☐	☐
10. Heart attack (MI)	☐	☐
11. Palpitations (irregular heartbeat)	☐	☐
12. Hypertension	☐	☐
13. Congestive heart failure	☐	☐
14. Heart murmur	☐	☐
15. Rheumatic fever history	☐	☐
16. Deep vein thrombosis (blood clots)	☐	☐
17. Asthma	☐	☐
18. COPD/Emphysema	☐	☐
19. Shortness of breath	☐	☐
20. Pulmonary embolus	☐	☐
21. Sleep apnea	☐	☐
22. TB exposure	☐	☐
23. Chronic cough or coughing blood	☐	☐
24. Abnormal chest x-ray	☐	☐
25. Anesthesia complications/reaction	☐	☐
26. GERD/heartburn	☐	☐
27. Difficulty swallowing	☐	☐
28. Nausea/vomiting	☐	☐
29. Chronic diarrhea	☐	☐
30. Chronic constipation	☐	☐
31. Bloody stools	☐	☐
32. Ulcers	☐	☐
33. Jaundice	☐	☐
34. Hepatitis/Liver disease	☐	☐
35. Kidney stones	☐	☐
36. Kidney failure	☐	☐

	Yes	No
37. Frequent urinary infections	☐	☐
38. Incontinence	☐	☐
39. Difficulty voiding	☐	☐
40. Rash	☐	☐
41. Itching	☐	☐
42. New skin lesions/moles	☐	☐
43. Skin cancer history	☐	☐
44. Stroke	☐	☐
45. TIAs or “mini-stroke”	☐	☐
46. Seizures	☐	☐
47. Frequent headache/migraines	☐	☐
48. Memory difficulties	☐	☐
49. Arthritis	☐	☐
50. Chronic back pain	☐	☐
51. Diabetes	☐	☐
How controlled? _____		
52. Thyroid problems	☐	☐
53. Adrenal problems	☐	☐
54. Anxiety	☐	☐
55. Depression	☐	☐
56. Psychiatric hospitalization	☐	☐
57. Easy bruising or bleeding	☐	☐
58. Transfusion history	☐	☐
59. Anemia	☐	☐
60. Lymph node enlargement/pain	☐	☐
61. Frequent illnesses	☐	☐
62. Immune system problems	☐	☐

Please explain “yes” answers:

_____

_____

_____

_____

_____

_____

_____

_____

Social History

Are you: ☐ married ☐ single ☐ divorced ☐ widowed ☐ cohabitating?

Spouse's/partner's name: _____

Your Occupation: _____

Religious preference: _____

	Yes	No
Do you currently smoke cigarettes? Packs per day _____ x _____ years	☐	☐
Would you like information to help you stop smoking?	☐	☐
If you've quit smoking, how long ago did you quit?_____ How long did you smoke? _____		
Do you chew tobacco?	☐	☐
Do you drink alcohol? How much? _____ How often?_____	☐	☐
Street/recreational drug use? Current: _____ Past: _____	☐	☐
Caffeine consumption? How much? _____	☐	☐
WOMEN - Are you or could you be pregnant? When was your last menstrual period? _____	☐	☐

Are you on a special diet?
- ☐ Vegetarian?
- ☐ Food intolerances _____
- ☐ Other?_____

Have you eaten less than half your usual meals in the past week?	☐	☐
Have you lost more than 20 lbs. in the past 6 months without trying?	☐	☐

Do you have any cultural or religious beliefs that may require special care or education on our part?

_____

_____