|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name |  |  |  |  |  |  |  |  |  |  |  | DOB |  |  |  | Age |  |  |
|  | Last |  | First | | Middle | |  |  |  |  |  |  |  |  |  |  |  |  |
| Ht |  | Wt |  |  | Sex: M F | | Marital status: | |  | Single |  | Married | |  | Widowed | |  | Divorced |
| Date of last physical exam | | |  |  |  | Doctor |  |  |  |  | Referring Doctor | | | |  |  |  |  |
| Phone |  |  |  |  | Purpose of consultation | | | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **PAST MEDICAL HISTORY:** | | | Do you have or have had? (if yes, give date of occurrence) | | | | | | | |  |  |  |  |  |  |  |  |
| AIDS or HIV | | N | Y |  |  |  | Bleeding tendencies | | |  | N | Y |  |  |  |  |  |  |
| Thyroid | | N | Y |  |  |  | Blood pressure | |  |  | N | Y |  |  |  |  |  |  |
| Heart |  | N | Y |  |  |  | Lungs | |  |  | N | Y |  |  |  |  |  |  |
| Kidneys | | N | Y |  |  |  | Nervous problems | | |  | N | Y |  |  |  |  |  |  |
| Gallbladder | | N | Y |  |  |  | Bleeding problems | | |  | N | Y |  |  |  |  |  |  |
| Stomach | | N | Y |  |  |  | Diabetes | |  |  | N | Y |  |  |  |  |  |  |
| Hepatitis | | N | Y |  |  |  | Cancer | |  |  | N | Y |  |  |  |  |  |  |
| Asthma | | N | Y |  |  |  | Fibromyalgia | |  |  | N | Y |  |  |  |  |  |  |
| Lupus |  | N | Y |  |  |  | Scleroderma | |  |  | N | Y |  |  |  |  |  |  |
| Arthritis | | N | Y |  |  |  | Other serious illnesses you have had | | | | | |  |  |  |  |  |  |
| Do you regularly smoke? | | | **Y N** How much per day? | | | | |  |  |  |  |  |  |  |  |  |  |  |
| Do you regularly drink over 3 cups of coffe per day? | | | | | | |  | **N Y** |  |  |  |  |  |  |  |  |  |  |
| Do you regularly drink alcohol or beer? **Y N**  How much per week? | | | | | | | | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **MEDICATIONS:** Are you presently taking any of the following? (circle) | | | | | | | | |  |  |  |  |  |  |  |  |  |  |
| Aspirin/Anacin | | Cough medicine | | | | Antibiotics | |  |  | Phenobarbital | | |  | Dilantin | | |  |  |
| Bufferin | | Thyroid pills | | |  | Blood pressure pills | | |  | Blood thinners | | |  | Iron | |  |  |  |
| Ibuprolan | | Hormones | | |  | Insulin/diabetic pills | | |  | Digitalls | |  |  | Sleeping pills | | |  |  |
| Motrin | | Birth control pills | | | | Arthritis medication | | |  | Cortisone | |  |  | Water pills | | |  |  |
| Other medication not listed | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Do you take herbal suplements? **Y N** If yes, What are they? | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |
| Aspirin and aspirin type products can cause excessive bleeding during surgery. | | | | | | | | | |  |  |  |  |  |  |  |  |  |
| DRUGS OR SUBSTANCES TO WHICH YOU ARE ALLERGIC | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |
| **FAMILY HISTORY**: Have blood relatives had? (please circle and give reason) | | | | | | | | |  |  |  |  |  |  |  |  |  |  |
| High blood pressure | |  |  |  |  | Arthritis | |  |  |  |  | Asthma | |  |  |  |  |  |
| Diabetes | |  |  |  |  | Stroke |  |  |  |  |  | Goiter | |  |  |  |  |  |
| Bleeding disorders | |  |  |  |  | Breast cancer | |  |  |  |  | Other cancer | | |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **SERIOUS ILLNESSES OR INJURIES:** Please list any serious illnesses or injuries and dates. | | | | | | | | | | |  |  |  |  |  |  |  |  |
| Illness / Injury | |  |  |  |  |  |  |  |  | Year |  |  |  |  |  |  |  |  |
| Illness / Injury | |  |  |  |  |  |  |  |  | Year |  |  |  |  |  |  |  |  |
| Illness / Injury | |  |  |  |  |  |  |  |  | Year |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **OPERATIONS**: Please list operations and year. | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Operation |  |  |  |  |  |  | Year |  |  | Operation | |  |  |  |  |  | Year |  |
| Operation |  |  |  |  |  |  | Year |  |  | Operation | |  |  |  |  |  | Year |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **WOMEN ONLY** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Is there a chance you may be pregnant? **Y N** | | | | | |  | Regular menses? | |  | **Y N** |  | Date of last menstrual period? | | | | |  |  |
| Any complications with pregnancies? | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| How many pregnancies? | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of last mammogram | | |  |  |  | How many children? \_\_\_\_\_\_\_\_\_\_\_ | | | | | Did you breastfeed? Y N How many? | | | | | | | |
| Specify abnormality | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Breast cancer: L R | | |  | Date |  |  |  |  | Mastectomy | |  |  |  |  |  | Date |  |  |
| Breast biopsy: L R | |  |  | Date |  |  |  |  | Oncologist | |  |  |  |  |  |  |  |  |
| Surgeon for breast biopsy | | |  |  |  |  |  |  | Address | |  |  |  |  |  |  |  |  |
| Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |