|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |