



**Name:**

(Please print clearly)

**Date of Birth:**

**Surgical History:** Check the appropriate box (es) to indicate your surgical history. Include the date of the surgery, if known and specify (R) right, (L) left, or (B) bilateral when applicable. Please use the 'Other' boxes to record your Surgical History if it is not on the list below.

- No major medical problems
- Abdominal Surgery (specify) \_\_\_\_\_
- Termination of Pregnancy \_\_\_\_\_
- Adenoidectomy \_\_\_\_\_
- Amputation (specify) \_\_\_\_\_
- Anesthesia Problem: No
- Anesthesia Problem: Yes, specify reaction \_\_\_\_\_
- Aortic Valve Replacement \_\_\_\_\_
- Appendectomy \_\_\_\_\_
- Arterial Blockage repair \_\_\_\_\_
- AV Fistula Creation \_\_\_\_\_
- (AAA) Repair \_\_\_\_\_
- A-F Bypass R L B
- Back Surgery (specify) \_\_\_\_\_
- Breast Implants (enlarge) R L B
- Breast (Lumpectomy) R L B
- Breast Reduction R L B
- Breast Surgery (specify) R L B
- Bronchoscopy \_\_\_\_\_
- Bunion Metatarsal, part removal of \_\_\_\_\_
- CABG \_\_\_\_\_
- Cardiac Surgery (specify) \_\_\_\_\_
- Carotid Endarterectomy R L B
- Carpal Tunnel R L B
- Cataract Extraction \_\_\_\_\_
- Cervical Spine Disk Surgery \_\_\_\_\_
- Cesarean Section \_\_\_\_\_
- Colectomy \_\_\_\_\_
- Cholecystectomy (Gall Bladder removal) \_\_\_\_\_
- Colon Resection \_\_\_\_\_
- Coronary Artery Stent \_\_\_\_\_
- Craniotomy \_\_\_\_\_
- Cystoscopy \_\_\_\_\_
- Dilation & Curettage (D&C) \_\_\_\_\_
- Dental Procedure \_\_\_\_\_
- Fundoplasty (laparoscopy) \_\_\_\_\_
- Gastric Bypass \_\_\_\_\_
- Glaucoma Surgery R L B
- Hemorrhoidectomy \_\_\_\_\_
- Hip Replacement-total R L B
- Ileostomy / Jejunostomy \_\_\_\_\_
- Interventional pain procedure \_\_\_\_\_
- Knee Arthroscopy R L B
- Knee Replacement R L B
- Kyphoplasty \_\_\_\_\_
- Laparoscopic-Gastric Band \_\_\_\_\_

- Laparoscopy, Diagnostic \_\_\_\_\_
- Lumpectomy w/nodes (breast) R L B
- Mastectomy R L B
- Mitral Valve Replace \_\_\_\_\_
- Nephrectomy R L B
- Oophorectomy R L B
- Pacemaker \_\_\_\_\_
- Parathyroidectomy \_\_\_\_\_
- Pneumonectomy R L B
- Post-op delirium \_\_\_\_\_
- Prostatectomy \_\_\_\_\_
- PTCA \_\_\_\_\_
- Remove Kidney Stone R L
- Remove Kidney-partial R L
- Repair Inguinal Hernia R L
- Repair Umbilical Hernia \_\_\_\_\_
- Rhinoplasty \_\_\_\_\_
- Rotator Cuff Repair R L B
- Shoulder Manipulation w/anesth R L B
- Shoulder Surgery R L B
- Sinus Surgery \_\_\_\_\_
- Spinal Fusion \_\_\_\_\_
- Spinal Fusion-Neck \_\_\_\_\_
- Splenectomy \_\_\_\_\_
- Surgical Complication: No
- Surgical Complication: Yes, specify \_\_\_\_\_
- Total Abd. Hysterectomy w/BSO \_\_\_\_\_
- Total Abd. Hysterectomy \_\_\_\_\_
- Total Vaginal Hysterectomy \_\_\_\_\_
- TURP (prostate) \_\_\_\_\_
- Thyroidectomy \_\_\_\_\_
- Thyroidectomy- Partial \_\_\_\_\_
- Tonsillectomy \_\_\_\_\_
- Transplant of Kidney R L
- Tunneled Dialysis Catheter \_\_\_\_\_
- Tympanostomy Tube \_\_\_\_\_
- UPPP \_\_\_\_\_
- Urinary incontinence surgery \_\_\_\_\_
- Vertebroplasty \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**Please be sure your name and date of birth are written on this form.**

**Name:**

(Please print clearly)

**Date of Birth:**

**Family Medical History:** Check the appropriate box (es) to indicate your family history and list which family member was diagnosed (father, mother, brother, sister, etc). List the age when diagnosed if known. Please use the 'Other' boxes to record your Family Medical History if it is not on the list below.

- Unknown Family Medical History
- Adopted Unknown Family Medical History
- Alcoholism \_\_\_\_\_
- Alzheimer's \_\_\_\_\_
- Anemia \_\_\_\_\_
- Anesthetic Complication \_\_\_\_\_
- Angina \_\_\_\_\_
- Anxiety \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Asthma \_\_\_\_\_
- Bipolar Disorder \_\_\_\_\_
- Birth Defects \_\_\_\_\_
- Bleeding Disease \_\_\_\_\_
- Breast Cancer \_\_\_\_\_
- Cervical Cancer \_\_\_\_\_
- Coronary Heart Disease (CHD) <65 female \_\_\_\_\_
- Coronary Heart Disease (CHD) <55 male \_\_\_\_\_
- Colon Cancer \_\_\_\_\_
- Depression \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Endometriosis \_\_\_\_\_
- Growth Development \_\_\_\_\_
- High Cholesterol \_\_\_\_\_
- Headaches \_\_\_\_\_
- Heart Disease \_\_\_\_\_

- High Blood Pressure \_\_\_\_\_
- Kidney Disease \_\_\_\_\_
- Lung Cancer \_\_\_\_\_
- Lung/Respiratory Disease \_\_\_\_\_
- Melanoma \_\_\_\_\_
- Migraines \_\_\_\_\_
- Osteoporosis \_\_\_\_\_
- Ovarian Cancer \_\_\_\_\_
- PMS \_\_\_\_\_
- Parkinson's \_\_\_\_\_
- Polycystic Kidney \_\_\_\_\_
- Prostate Cancer \_\_\_\_\_
- Psychiatric Care \_\_\_\_\_
- Seizures \_\_\_\_\_
- Severe Allergies \_\_\_\_\_
- Suicide \_\_\_\_\_
- Stroke \_\_\_\_\_
- Thyroid Problems \_\_\_\_\_
- Uterine Cancer \_\_\_\_\_
- Weight Disorder \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**Social History:** circle or print answers below.

Marital Status:      Divorced   Life Partner   Married   Separated   Single   Widowed

Number of Children:   none   1   2   3   4   5   6   7   other \_\_\_\_\_

Occupation: \_\_\_\_\_

Smoker:              Never          Former      Current

Alcohol use:        Yes            No

Regular Exercise:    Yes            No

Helmet use:         Yes            No

Smoke Detector:    Yes            No

Seat Belt use:        Yes            No

**Health Maintenance:** Please indicate the date(s) performed, approximate if necessary, if you have received the following tests:

Colonoscopy:

Bone Density/Dexa Scan:

Mammograms:

\* If your medication list does not fit on this form, upon your request some pharmacies may provide you with a print out of your medications. If you wish, the pharmacy print out may be attached to this form, or you may attach your own written list to this form.

**Please be sure your name and date of birth are written on this form.**

**For Internal Use Only, Entered By:** \_\_\_\_\_