

Name _____

Date _____

Height _____

Weight _____

DOB _____

Family History:

How are you related:

Diabetes _____

Breast Cancer _____

Other Cancers (specify) _____

Bleeding Problems _____

Blood Clots _____

Anesthesia Problems _____

Patient History:

List your surgeries with approximate dates:

List of medications you take – include the dosage and number of times you take them each day:

List of medications you are allergic to: _____

Allergy to Latex or rubber products? _____

Do you have a smoking history? _____

If currently smoking, how much per day? _____

If you quit, how long ago? _____

Do you have a history of any of the following? – include approximate year:

Skin problems _____

Hepatitis _____

Eye problems _____

Chronic liver diseases _____

Dry eyes _____

Chronic kidney diseases _____

Diseases of ears _____

Urinary tract infections _____

Diseases of nose _____

Kidney stones _____

Diseases of throat _____

Numbness _____

Chronic dry mouth _____

Headaches _____

Thyroid disorders _____

Seizures _____

Diabetes _____

Epilepsy _____

Rheumatic heart disease _____

Heart murmur _____

High blood pressure _____

Convulsions _____

Heart attack _____

Angina _____

Other heart diseases _____

Trouble breathing _____

Anemia _____

Asthma _____

Blood clots _____

Emphysema _____

Bleeding disorders _____

Bronchitis _____

Bruising _____

Pneumonia _____

Tuberculosis _____

Breast disease _____

Spastic problems _____

Unexplained fevers _____

Gynecological problems _____

First Day of last

Last PAP smear _____

menstrual period _____

Chronic nausea, vomiting _____

Constipation or diarrhea _____

Jaundice _____

Any other serious or

Stomach problems _____

chronic medical illness _____

or ulcers _____

Patient Signature