SURGICAL PROFESSIONALS

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Medical History

Name: **Age:** **Height:** **Weight:** **Date:**

Who is your primary care provider or referring physician? **What is their phone number?**

What is your primary problem today?

What other medical problems do you have or have recently been treated for? (i.e. diabetes, hypertension, heart disease, etc)

Have you had prior surgeries? (Circle if YES, cross out if NO)

appendectomy	heart surgery, cardiac catheterization,or pacemaker	Other surgeries? (specify)
gallbladder	lung surgery	
bowel surgery	groin hernia	
hysterectomy	abdominal wall hernias	

Did you have any complications with the surgery or the anesthesia previously? Y / N

What medical conditions run in your family/relatives? (Circle if YES, cross out if NO)

Stroke	Breast Cancer	Blood disorders
Heart disease	Colon Cancer	Major problems with anesthesia
Heart attack	Lung Cancer	Other (specify)
	Other Cancers (list type)	

Do you smoke? Y / N	If yes, how many packs a day?	How many years in total?
Do you drink alcohol? Y / N	If yes, how many drinks a day?	
Do you have a history of drug abuse? Y / N	If yes, please specify	
What is your current occupation?		

Please circle if you have had problems with the following recently.

severe headaches	chest pain	unintended weight loss	numbness/weakness
loss of vision	diarrhea	unusually easy bruising	fever or chills
severe lightheadedness	blood in the stool	bleeding	Other (specify)
loss of consciousness	burning on urination	palpitations	
shortness of breath	blood in the urine	cough or congestion	

Do you have any ALLERGIES to medications or to shellfish/iodine/IVP dye? (specify)

Please list all medications you are currently taking, including over the counter and herbal.

Are you taking or have you recently taken any of the following

Aspirin	Y / N		
Prednisone or other steroids	Y / N		
Coumadin or other blood thinners		Y / N	
Plavix or Lovenox	Y / N		

Any recent blood work?	Y / N
EKG	Y / N
Echo or stress test	Y / N