

Briefly describe the reason for today's visit: _____

MEDICAL HISTORY

SURGICAL HISTORY

Check all items that apply to you. Give approximate date of diagnosis.	YES	DATE	Check all items that apply to you. Give approximate date of procedure.	YES	DATE
Heart Attack			you		
High Blood Pressure			Ear Surgery		
Heart Rhythm (fast, slow, irregular)			Tonsils		
Heart Valve Problem			Adenoid		
Antibiotics for your heart for dental work			Deviated Nasal Septum		
Heart Catherterization and/or Stents			Sinus Surgery		
High cholesterol			Thyroid Surgery		
Pneumonia			Neck Mass Removed		
Asthma			Neck cyst Removed		
Emphysema or COPD			vocal Cord Surgery		
Reflux (GERD)			Tracheotomy		
Hiatal Hernia			Pacemaker		
Ulcer			Heart Bypass		
Hepatitis			Heart Valve		
Irritable Bowel Syndrome			Carotid Artery		
Diverticulitis			Appendix		
Men: Prostatitis			Gallbladder		
Women: endometriosis			Colon Surgery		
Kidney Infection			Hernia Repair		
Kidney Stone			Women: Tubes tied		
Thyroid problem			Women: Hysterectomy		
diabetes			Women: Breasts Lump		
Carotid Artery Blockage			Men: Vasectomy		
Aneurysm of Aorta			Men: Prostate surgery		
Clots in Legs or Lungs			Spine Surgery, Neck		
Stroke or TIA ("mini stroke")			Spine Surgery, Back		
Anemia			Arthroscopy		
Sickle Cell Disease or Trait			Joint Replacement		
Neck or Back Problems			Cataract Surgery:		
Anxiety and/or Depression					
Eating Disorder			Colonoscopy		
Treated for Alcoholism or Substance Abuse			Esophagus Scope Exam		
Head Injury			Other not listed:		
Sleep Apnea					
Arthritis and/or Gout					
Parkinson's; Tremor; or movement problem			<input type="checkbox"/> Check here if NO items above apply to you		
Lupus, Sjogren's, or Wegener's			ANESTHESIA HISTORY		
HIV			Difficult Intubation		
Cancer (Indicate site and type):			Fever related to anesthesia		
			Slow to awaken from anesthesia		
			Excessive nausea from anesthesia		
<input type="checkbox"/> Check here if NO items above apply to			Family with anesthesia problem		

Dr.'s Dolgin, Donnelly, Davis, Vincent, Anderson

Patient Name: _____

Date: _____

MEDICATIONS, ALLERGIES, HABITS

MEDICATIONS	ALLERGIES		
Please list ALL medications that you take, with dosage and how often you take each one. (Include non-prescription medicines.) <input type="checkbox"/> I DO NOT use any medications regularly	<i>ALLERGIES TO MEDICATIONS:</i>	<i>REACTION:</i>	
	<input type="checkbox"/> I have NO allergies to medications		
	<i>INHALANTS ALLERGIES: (Circle)</i>		
	Pollen	Trees	Grass Weeds Dust Mold
	Cats	Dogs	Feathers
	<i>FOOD ALLERGIES: (Circle)</i>		
	Nuts	Eggs	Wheat Milk Shellfish
	<i>INSECT ALLERGIES: (Circle)</i>		
	Bees	Wasps	Other:
	<i>OTHER ALLERGY TRIGGERS: (Circle)</i>		
	Smoke	Perfume	Cleaners Chemical fumes Weather Changes
Have you been on allergy shots? No Yes If Yes, when?			
SOCIAL INFORMATION AND HABITS			
Marital Status:	Married	Single Divorced Widowed	
Your Occupation:			
If retired, what was occupation?			
How much water do you drink?			
How much caffeine do you drink?			
Do you currently smoke?	Yes	No	
How much per day?	How many years?		
If you quit smoking, when?			
How much did you smoke?	How many years?		
Do you drink alcohol?	No Yes	How much?	

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Patient Name: _____ Date: _____

