Name: ____ **Height**: ________ **Weight**: _________ **Age**: _________ **D.O.B**: ________________
(Please print)

MEDICATION
List dose or number of pills per day

Prescription Drugs:
____
____
____
____

Non-Prescription (Vitamins/ Herbs):
____
____
____
____

REGULAR ASPIRIN USE Y ☐ N ☐ Dosage & Frequency: ____
NSA (Advil, Motrin, or Ibuprofen) Y ☐ N ☐ Dosage & Frequency: ____
CORTISONE INJECTION WITHIN THE PAST YEAR Y ☐ N ☐ Dosage & Frequency: ____

PAST MEDICAL HISTORY:
HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Y/N	Notes
ANEMIA		
ANGINA		
ASTHMA		
ATRIAL FIBRILLATION		
BLEEDING DISORDER		
BREAST CANCER		
CANCER		
DIABETES		
ECZEMA		
GASTROINTESTINAL ESOPHAGEAL REFLUX DISEASE		
HEART DISEASE		
HEART MURMUR		
HEPATITIS		
HIGH BLOOD PRESSURE		
HIVES		
IDDM		
KIDNEY STONES		
SKIN CANCER		
SKIN DISEASE		
SLEEP APNEA		
SNORING		
STROKE		
THYROID DISORDER		
ULCERS		
URINARY TRACT INFECTION		
WEIGHT CHANGE WITHIN THE LAST 6 MONTHS		
OTHER Serious Illness		
DO YOU OR A FAMILY MEMBER HAVE A HISTORY OF MALIGNANT HYPERTHERMIA?		
HAS THERE BEEN UNEXPECTED DEATHS IN YOUR FAMILY FOLLOWING GENERAL ANESTHESIA OR EXERCISE		
DO YOU OR A FAMILY MEMBER HAVE A MUSCLE OR NEUROMUSCULAR DISORDER		
DO YOU OR A FAMILY MEMBER HAVE A HIGH TEMPERATURE FOLLOWING EXERCISE		
DO YOU OR A FAMILY MEMBER HAVE A HISTORY OF MUSCLE SPASMS		
DO YOU OR A FMAILY MEMBER HAVE A HISTORY OF DARK OR CHOCOLATE COLORED URINE		
DO YOU OR A FAMILY MEMBER HAVE A HISTORY OF AN UNANTICIPATED FEVER IMMEDIATELY FOLLOWING ANESTHESIA OR A SERIOUS EXERCISE		

FAMILY HISTORY:
HAVE ANY BLOOD RELATIVES EVER HAD ANY OF THE FOLLOWING?

	Y/N	AFFLICTED FAMILY MEMBER	NOTES
ABNORMAL BLEEDING			
ABNORMAL CLOTTING			
ADOPTED			
ANESTHESIA PROBLEMS			
AUTOIMMUNE DISORDERS			
BRAIN TUMOR			
BREAST CANCER			
CLEFT LIP			
CLEFT PALATE			
DIABETES			
DRUG ALLERGIES			
ENDOCRINE DISEASE			
HEARING LOSS			
HEART DISEASE			
HEMOPHILIA			
HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
LIVER DISEASE			
LUNG CANCER			
MALIGNANT HYPERTHERMIA			
OTHER CANCER			
OVARIAN CANCER			
PROSTATE CANCER			
SKIN CANCER			
SKIN DISEASE			
SUBSTANCE ABUSE			
VON WILLEBRAND			

PAST SURGICAL HISTORY:

SURGERY/HOSPITALIZATION	DATE	ANESTHESIA COMPLICATIONS	NOTES

ALLERGIES:

ALLERGY	REACTION	NOTES

SOCIAL HISTORY

ALCOHOL	STD	SMOKING HISTORY
		SMOKING STATUS
☐ Denies Alcohol Use	☐ Denies STD History	
☐ Admits Alcohol Use Socially		STARTED
☐ Admits Alcohol Use Daily	☐ Admits STD History	
☐ Admits to History of Alcoholism		ENDED
DRUGS		
☐ Denies Using Illegal Drugs		Cessation Counseling (OFFICE ONLY)
☐ Admits to Using Illegal Drugs		
☐ Admits to History of Drugs Abuse		

Have Your Received a Flu Shot?
☐ Influenza Vaccination Declined
☐ Previous Receipt of Influenza Vaccination; on their own
☐ Previous Receipt of Influenza Vaccination; at surgery
☐ Previous Receipt of Influenza Vaccination; at hospital
☐ Previous Receipt of Influenza Vaccination; at work
☐ Allergy to Eggs
☐ Allergy to Influenza Vaccine

Please describe questions with a"Yes"answer:____
____

Have you ever had a transfusion? Y ☐ N ☐ If yes, what year? ________________________

Have you been tested for HIV? Y ☐ N ☐ If yes, what year?_ ________________________ Test Results: Pos ☐ Neg ☐

Have you been tested for STD's? Y ☐ N ☐ If yes, what year? ________________________ Test Results: Pos ☐ Neg ☐

Do you wear: Contact Lenses: Y ☐ N ☐ Eyeglasses: Y ☐ N ☐ Hearing Aid: Y ☐ N ☐ Dentures: Y ☐ N ☐

Previous Surgery, Year and Type of Procedure:____

Have you had cosmetic surgery before: Y ☐ N ☐

Indicate the type(s) of anesthesia received in the past, list any complications / reactions you experienced:

☐ Local Anesthesia-complications reactions:____

☐ General Anesthesia-complications / reactions:____

☐ Spinal / Epidural-complications / reactions:____

Date last seen by Primary Care Physician:____

Primary Care Physician (Name)________________________(Phone)________________________
(Address)____

Are you under the care of a Pain Physician: Y ☐ N ☐

FEMALE PATIENTS ONLY:

What is your current bra size now? ____________

When was your most recent Mammogram? _________________ Results: Normal? Y ☐ N ☐ If No, Describe____________________

Number of Pregnancies: _________Number of Children: __________Last Menstrual Period: ________________Did you Breast Feed? Y ☐ N ☐

☐ I have read and understand the Notice of Privacy Act that was provided to me at my time of visit.

Signature of Patient:____ **Date_______/______/______**

(please sign)