

## To Our Patients:

You are scheduled for a history and physical (H&P) examination on \_\_\_\_\_ at \_\_\_\_\_ with \_\_\_\_\_.

Please complete this ENTIRE form and bring it with you to your scheduled appointment. This is used to up date your medical history and reduce the risks of complications from surgery and anesthesia.

Thank you for your assistance.

Your name: \_\_\_\_\_

Place of Surgery: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Surgeon: \_\_\_\_\_

PAST MEDICAL HISTORY (please list year each issue occurred)

Any unusual childhood illnesses:

\_\_\_\_\_

\_\_\_\_\_

Past hospitalizations and surgeries:

\_\_\_\_\_

\_\_\_\_\_

Medical Problems:

\_\_\_\_\_

\_\_\_\_\_

If you are female, what was the date of your last menstrual period?

\_\_\_\_\_

CURRENT MEDICATIONS (please list both prescription and non-prescription)

\_\_\_\_\_

\_\_\_\_\_

MEDICATIONS (CONTINUED)

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MEDICATION ALLERGIES (including type of reaction)

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**Any history of Latex sensitivity or allergy: yes\_\_\_no\_\_\_**

SOCIAL HISTORY

Marital status: married\_\_\_ single\_\_\_ divorced\_\_\_ widow\_\_\_

Do you have children? yes\_\_\_ no\_\_\_

If yes, what are there names and ages:

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Your occupation: \_\_\_\_\_

Last year of school completed: \_\_\_\_\_

Tobacco use: yes\_\_\_ no\_\_\_

If yes how many packs per day \_\_\_\_\_

Do you use chewing tobacco? yes\_\_\_no\_\_\_

Alcohol use:

How many days per week do you typically drink alcohol? \_\_\_\_\_

How many alcohol drinks per week will you usually have? \_\_\_\_\_

Any other drug use? \_\_\_\_\_

Any concerns about sexuality or sexual function? \_\_\_\_\_

FAMILY HISTORY

Please list any illness in your family members including heart disease, stroke, diabetes, cancer, high blood pressure, high cholesterol levels, lung disease, liver or kidney disease, depression or suicide.

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brothers or sisters: \_\_\_\_\_

Children: \_\_\_\_\_

Grandparents: \_\_\_\_\_

**DO YOU OR ANYONE IN YOUR FAMILY HAVE BAD REACTIONS TO ANESTHESIA?** Yes \_\_\_ No \_\_\_

If yes please explain: \_\_\_\_\_

**DO YOU OR ANYONE IN YOUR FAMILY HAVE BLEEDING PROBLEMS?**

Yes \_\_\_ No \_\_\_

If yes please explain: \_\_\_\_\_

PLEASE CHECK ANY PROBLEMS LISTED BELOW THAT YOU HAVE HAD AND NOTE ANY DETAILS INCLUDING WHEN THIS OCCURRED.

\_\_\_ FEMALES: last menstrual period \_\_\_\_\_

\_\_\_ Fever, chills, night sweats

\_\_\_ Headaches, head injuries, concussion

\_\_\_ Eye problems (wear contacts or glasses?)

\_\_\_ Loose or capped teeth?

\_\_\_ Cold or allergy symptoms

\_\_\_ Ear problems, hearing loss, ringing, pain

\_\_\_ Thyroid problems or x-ray treatment to neck or chest

\_\_\_ Breast masses, breast discharge, breast pain

\_\_\_ Breathing problems, shortness of breath, asthma, bronchitis, pneumonia, emphysema

\_\_\_ High blood pressure, chest pain, palpitations or skipped beats, heart murmur

\_\_\_ Heartburn, ulcers, gallstones, bowel changes, bloody or black bowel movements, abdominal pain

\_\_\_ Kidney or bladder infection, leaking urine, pain with urination, kidney stones

\_\_\_ Muscle pain, joint pain or swelling, broken bones, dislocations, muscle weakness

\_\_\_ Seizure, loss of coordination, tremors, speech problems, memory loss, numbness, tingling

\_\_\_ Skin changes, mole change, skin infections, hair loss, psoriasis

\_\_\_ Abnormal bleeding from any site, clotting problems, bruising easily, transfusion

If yes to transfusions, what year was this done and why? \_\_\_\_\_

\_\_\_ Depression, poor sleeping, appetite problems, panic attacks, suicidal thoughts or attempts

**PLEASE BRING ANY IMMUNIZATION DATES FOR TETANUS, PNEUMOVAX OR RECENT FLU SHOTS IF YOU HAVE THESE RECORDS.**

PREOPERATIVE CLEARANCE MAY REQUIRE: LABS, XRAYs OR EKGs. WE WILL ALSO DO OUR BEST TO UPDATE ALL RECOMMENDED HEALTH MAINTENANCE ITEMS AT THE TIME OF THIS VISIT OR, IF TIME IS LIMITED, WE WILL SCHEDULE THESE BEFORE YOU LEAVE.