Patient Name: ______________________________ **DOB:** ______/________/________

ETHNIC GROUP: (please circle) **Hispanic** **Not Hispanic or Latino** **I choose not to specify**

Preferred Language:__________________ **Race:** ____________________

Past Medical History: (Please circle all that apply)

- None
- Adrenal Insufficiency
- Anemia/Thalassemia
- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Autoimmune Disease
- Bone Marrow Transplant
- Benign Prostatic Hyperplasia
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- Easy Bruising
- End Stage Renal Disease
- GERD
- Indigestion
- Head Trauma
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer/Disease
- Lupus
- Lymphoma
- Malignant Hypertension
- Mental Health Hospitalization
- Neuromuscular Disorder
- Paralysis
- Pneumothorax
- Prostate Cancer
- Pulmonary Embolism
- Radiation Treatment
- Reflux
- Renal Disorder
- Rheumatoid Arthritis
- Seizures
- Severe Reaction to ▪Anesthesia
- Sleep Apnea (cpap/no cpap)
- Snoring
- Stroke
- Trauma
- Valvular Heart Disease
- Vision Loss
- Other:
  ____
  ____
  ____
  ____

Past Surgical History: (Please circle all that apply)

- None
- Appendix Removed
- Abdomen: Laparoscopy
- Abdomen: Laparotomy
- Hernia Repair:__________
- Bladder Removed
- Brain Surgery (cancer/ trauma)
- Breast Biopsy (right, left, bilateral)
- Lumpectomy (right, left, bilateral)
- Mastectomy (right, left, bilateral)
- C- Section
- Colectomy
- Colostomy
- Coronary Artery Bypass
- Angioplasty (PTCA)
- Gallbladder Removed
- Biological Valve Replacement
- Mechanical Valve Replacement
- Heart Transplant
- Hip Replacement(right, left, bilateral)
- Knee Replacement (right, left, bilateral)
- Kidney Biopsy
- Kidney Stone Removal
- Kidney Removed (right, left)
- Kidney Transplant
- Liver Resection/Hepatectomy
- Liver Transplant
- Liver Shunt
- Lung Lobectomy (right, left)
- Pneumonectomy (right, left)
- Ovaries Removed
- Tubal Ligation
- Pancreas Removed
- Prostate Removed (cancer, TURP)
- Rectal Resection
- Small Bowel Resection
- Spine Surgery
- Spleen Removed
- Stomach Removed
- Gastrostomy
- Testicles Removed
- Hysterectomy
- Other:
  ____
  ____
  ____
  ____
  ____

Patient Name: ______________________________ DOB: _____/______/________

Skin Disease History: (Please circle all that apply)

- None
- Acinitic Keratoses
- Basal Cell Carcinoma
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking/Itchy Scalp
- Hay fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Carcinoma

Do you wear sunscreen? (Please Circle)	YES	NO	If yes, what SPF: ____________
Do you tan in a tanning bed? (Please Circle)	YES	NO	
Do you have a family history of Melanoma? (Please Circle)	YES	NO	If yes, which relative: ________

Plastic Surgery History: (Please circle all that apply)

- None
- Abdominoplasty
- Brachioplasty
- Liposuction
- Lower Body Lift
- Thigh Lift
- Upper Body Lift
- Breast Augmentation
- Breast Reconstruction
- Breast Lift (Mastopexy)
- Breast Reduction
- Carpal Tunnel Release
- Otoplasty
- Blepharoplasty
- Browlift
- Facelift
- Facial Fracture Repair
- Frontal Sinus Fracture
- Orbital Floor Fracture
- Wrist Fracture Repair
- Rhinoplasty
- Septoplasty
- Maxillary Fracture
- Mandible Fracture
- Hand Surgery

Other:
____
____
____
____

Do you have a family history of Breast Cancer?	YES	NO	If yes, who: ______________
Do you have a family history of Malignant Hypothermia or Severe Reactions to anesthesia?	YES	NO	If yes, which relative: ________

Herbal Medications or Supplements: (Please circle all that apply)

- None
- Anabolic Steroids
- Androstenedione
- Black Cohosh
- Cat's claw
- Chondroitin
- Cranberry
- Echinacea
- Ephedra
- Evening Primrose
- Feverfew
- Fish Oil
- Flaxseed Oil
- Garlic
- Gingko Biloboa
- Ginseng
- Glucosamine
- Green Tea
- Hawthorn
- HCG
- Horse chestnut
- Human Growth Hormone
- Kava
- Licorice Root
- Mistletoe
- Peppermint
- Phentermine
- Saw Palmetto
- St. John's Wart
- Valerian
- Vitamin (A, B, C, D, E)
- Other:

____

Medications: (Please list all medications. If you are not currently taking any please circle "No Medications)

NO MEDICATIONS

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Drug Allergies: (Please list all known allergies, if none please circle "No Known Drug Allergies")

NO KNOWN DRUG ALLERGIES

______________ ______________ ______________

Patient Name: ____ DOB: ______/________/_________

Social History: (Please circle the choice which applies)

Smoking Status:

- Current Every Day Smoker
- Current Someday Smoker
- Former Smoker
- Never Smoker

Alcohol Use:

- None
- < 1 Drink per day
- 1-2 Drinks per day
- 3 or more drinks per day

Occupation: ____

ALERTS: (Please circle all that apply)

▪ None	▪ Artificial Joint Replacement	▪ Pregnancy or Planning Pregnancy
▪ Allergy to adhesive	▪ Blood Thinners	▪ Rapid Heart rate with Epinephrine
▪ Allergy to latex	▪ Cardiac Stents	▪ Require antibiotic prior to surgery
▪ Allergy to Lidocaine	▪ Defibrillator/Pacemaker	▪ Thyroid Problems
▪ Allergy to topical antibiotic ointments	▪ Keloid Scarring	
▪ Artificial valve Replacement	▪ MRSA	

Review of Systems: (Are you currently experiencing any of the following?) Please circle yes or no

Are you in generally good health?	YES	NO	
Do you have problems with bleeding?	YES	NO	
Do you have problems with healing?	YES	NO	
Do you have problems with scarring?	YES	NO	
Do you currently have a rash?	YES	NO	
Do you have any new skin lesions?	YES	NO	
Do you have any changing skin lesions?	YES	NO	
Are you pregnant or currently trying to get pregnant?	YES	NO	
Have you previously had a flu vaccine?	YES	NO	If yes, when: _______________
Have you previously had a pneumonia vaccine?	YES	NO	If yes, when: _______________
Do you have a living will:	YES	NO	
Do you have a Medical Power of Attorney (for yourself)?	YES	NO	If yes, who: ___________________

Have you or any family members ever had any problems with anesthesia in the past?	YES	NO
Have you been admitted to the hospital in the past 12 months?	YES	NO
If yes, why? ____		
To your knowledge do you have a history of a difficult airway during previous surgeries?	YES	NO

Height: __________**ft.** __________ **in.** **Weight:** _______________ **lbs**

Patient Signature:____ **Date:**_____________________

Revised by RR 10/26/2017