

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)**

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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)**

<input type="checkbox"/> None	<input type="checkbox"/> Artificial Joint Replacement	<input type="checkbox"/> Pregnancy or Planning Pregnancy
<input type="checkbox"/> Allergy to adhesive	<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Rapid Heart rate with Epinephrine
<input type="checkbox"/> Allergy to latex	<input type="checkbox"/> Cardiac Stents	<input type="checkbox"/> Require antibiotic prior to surgery
<input type="checkbox"/> Allergy to Lidocaine	<input type="checkbox"/> Defibrillator/Pacemaker	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Allergy to topical antibiotic ointments	<input type="checkbox"/> Keloid Scarring	
<input type="checkbox"/> Artificial valve Replacement	<input type="checkbox"/> 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:** \_\_\_\_\_