



Please indicate your past medical history and family medical history by checking the appropriate boxes. Please include family member's relationship to you, i.e. mother, daughter, grandfather, etc. For other medical diseases not listed, please use the lines below the table.

Problem:	Self:	Family Member:	Problem:	Self:	Family Member:
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Relationship		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Relationship
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulosis/diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia, low blood count	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/ seizures	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/ Gout	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/ liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Breast	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Cervix/Ovary/Uterus	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Colon	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Lung	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Prostate	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Skin	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
COPD/ Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>

Other medical illnesses, not listed above: _____

Medications and Dosage: Please include vitamins and over-the-counter medications. NONE:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Allergies and Adverse Reactions: Please describe. (antibiotics, anesthetics, narcotics, latex, tape, etc.) NONE:



Previous Surgeries and Date Performed:

NONE:

(Appendectomy, Gallbladder, Laparoscopy, C-section, Tubal ligation, Tonsils, Breast biopsies, Colonoscopy/endoscopy, Joint or Bone surgeries, Heart angioplasty or stents, etc.)

Social History:

Married Single Divorced Widowed Occupation: _____

Do you drink alcohol? _____ How Much? _____ How Often? _____

Have you ever smoked? _____ How many years did you smoke? _____ When did you quit? _____

Do you use chewing tobacco? _____ How many packs/cans per day do you smoke/chew now? _____

Do you use illicit/illegal drugs? _____ What kind and how often? _____

Review of Systems: Check all that apply.

Constitutional: Fatigue Fever Chills Fainting Weight loss Weight gain

Eyes: Double vision Change in vision Blindness

Ear, Nose, Throat: Difficulty hearing Congestion Runny nose Nose bleeds Sore throat

Cardiovascular: Chest pain Skipped/extra heart beats Leg pain when walking Leg/ankle swelling

Respiratory: Shortness of breath Cough Wheezing Sputum

Gastrointestinal: Abdominal pain Nausea Vomiting Diarrhea Constipation Heartburn
Blood in bowel movements Difficulty swallowing/chewing Hemorrhoids

Genitourinary: Painful urination Bloody urine Kidney stones Groin hernia

Musculoskeletal: Difficulty walking Arthritis Back pain

Skin: Yellow skin (jaundice) Skin rash Skin problems _____

Neurologic: Headache Dizziness Seizures Confusion

Psychologic: Stress Depression Anxiety Poor sleeping

Endocrine: Thirsty Cold intolerance Heat intolerance

Hematologic: Easy bruising or bleeding Low blood count/ anemia

Immunologic: Splenectomy HIV/AIDS Seasonal allergies

Lymphatics: Swollen lymph glands

Any other symptom(s) that your surgeon should know about: _____

Printed Name: _____ Signature: _____ Date: _____