



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Reason for today's visit: \_\_\_\_\_

Current list of medications – Please list name, dosage and frequency. Include supplements (vitamins, herbs, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Does patient have a history of a bleeding disorder?  No  Yes Allergic to eggs?  No  Yes Allergic to soy?  No  Yes

Does patient have a personal history of anesthesia reaction?  No  Yes Details: \_\_\_\_\_

Does family member have a history of anesthesia reaction?  No  Yes Details: \_\_\_\_\_

**PAST MEDICAL HISTORY: (PLEASE CHECK BOX NEXT TO THE CONDITION PATIENT HAS NOW OR HAD IN THE PAST)**

Latex allergy

**EYES**

Glaucoma

Cataract

**ENT**

Hearing loss

Cholesteatoma

Recurrent tonsillitis

Chronic sinusitis

Nasal polyps

Broken nose

Broken facial bones

Sleep apnea

Meniere's disease

Otosclerosis

**CARDIOVASCULAR**

Hypertension/high BP

Coronary artery disease

Atrial fibrillation

Other arrhythmia

Congestive heart failure

Valvular heart disease

Varicose veins/phlebitis

**RESPIRATORY**

Asthma

COPD

Lung cancer

**GASTROINTESTINAL**

GERD/acid reflux

Peptic ulcer

GI bleed

Liver disease

Cirrhosis

Colon cancer

Crohn's disease

Diverticulitis

Renal failure

Kidney disease

Prostate enlarged

Prostate cancer

Recurrent UTI

Infertility

**MUSCULOSKELETAL**

Osteoarthritis

Osteoporosis

Rheumatoid arthritis

Broken bones

Muscular dystrophy

**NEUROLOGIC**

Cva/stroke

Brain tumor

Seizure disorder

Multiple sclerosis

Anxiety

Depression

Bipolar

Schizophrenia

**ENDOCRINE**

Diabetes type I

Diabetes type II/oral

Hypothyroidism

Hyperthyroidism

Thyroid disorder

**SKIN**

Skin disease

**HEM/LYMPHATIC**

Cancer

Anemia

Blood transfusion

Hyperlipidemia

Hypercholesterolemia

Deep vein thrombosis

Hemochromatosis

**ALLERGY/IMMUNOLOGIC**

Allergic rhinitis

Fibromyalgia

Hepatitis B

Hepatitis C

Tuberculosis

MRSA

HIV/AIDS

VRE

C.Difficile

Other: \_\_\_\_\_

Patient Name and date of birth: \_\_\_\_\_

**PAST SURGICAL HISTORY:**

**ENT**

- M&T (ear tubes)
- Stapedectomy
- Septoplasty
- Rhinoplasty
- Rhytidectomy (face lift)
- Sinus surgery
- Adenoidectomy
- Tonsillectomy
- UP3
- Tracheotomy
- Thyroidectomy
- Parathyroidectomy
- Parotidectomy left
- Parotidectomy right
- Submandibular gland excision left
- Submandibular gland excision right
- Neck dissection left
- Neck dissection right

**SKIN/CARDIO/RESP**

- Skin cancer removal
- AV fistula
- AV graft
- Port placement
- Aortic valve replacement
- Mitral valve replacement
- Pacemaker
- Vascular bypass
- Carotid endarterectomy
- CABG (heart bypass)
- Bronchoscopy
- Lung resection left
- Lung resection right

**EYES/GASTRO/GI**

- Cataract
- Lens replacement
- Blepharoplasty
- Abdominal surgery
- Appendectomy
- Cholecystectomy (gallbladder)
- Colon resection
- Gastric bypass
- Hemorrhoidectomy
- Kidney removal
- TURP
- Prostatectomy (open)
- Hysterectomy
- Cesarean section
- D&C
- Tubal ligation

**MS/Neuro**

- Back surgery
- Carpal tunnel
- Hip replacement
- Knee replacement
- Knee arthroscopy
- Kyphoplasty
- MS/Neuro
- Rotator cuff repair
- Interventional pain procedure
- Craniotomy/ brain surgery
- Amputation
- Brain tumor excision/biopsy

Other: \_\_\_\_\_

**For any surgeries you have undergone, did you have any of the following:**

- Anesthesia problem:       No    Yes
- Surgical complications:       No    Yes
- Post-op delirium:       No    Yes

OTHER: \_\_\_\_\_

Patient Name and date of birth: \_\_\_\_\_

**FAMILY HISTORY:**

- Alcoholism
- Allergy
- Anesthesia problems
- Arthritis
- Asthma
- Bleeding disorder
- Breast cancer
- Head/neck cancer
- CVA/stroke
- Depression
- Diabetes
- Hearing Loss
- Heart disease
- Hypertension
- Hyperlipidemia
- Migraines
- Renal disease
- Seizures
- Skin Cancer
- Suicide
- Thyroid disease

**SOCIAL HISTORY**

- Minor
- Single
- Married
- Divorced
- Separated
- Widowed
- Children -  
Yes, how many: \_\_\_\_\_
- Children - No
- Occupation: \_\_\_\_\_
- Lives Alone - Yes
- Lives Alone -  
No, with whom: \_\_\_\_\_
- History of domestic abuse
- Religion affecting care
- Immunizations current:  
 Yes  No  Unknown

**TOBACCO USE**

- Current everyday smoker:  
 No  Yes
- Former Smoker  
 No  Yes
- Calendar year started: \_\_\_\_\_
- Calendar year quit: \_\_\_\_\_
- Cigarettes:  No  Yes  
Amount/week: \_\_\_\_\_
- Cegars:  No  Yes  
Amount/week: \_\_\_\_\_
- Smokeless:  No  Yes  
Amount/week: \_\_\_\_\_
- Vape:  No  Yes  
Amount/week: \_\_\_\_\_
- Counseled to quit/cutdown:  No  Yes
- Passive smoke exposure:  No  Yes

**ALCOHOL USE**  No  Yes

- If yes, type: \_\_\_\_\_
- Drinks per day: \_\_\_\_\_
- Drinks per week: \_\_\_\_\_
- Drinks per year: \_\_\_\_\_
- Counseled to quit/cut down:  No  Yes
- Comments: \_\_\_\_\_

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

Patient Name and date of birth: \_\_\_\_\_

**REVIEW OF SYSTEMS: (CHECK THE BOX NEXT TO THE CONDITION THE PATIENT IS CURRENTLY EXPERIENCING)**

**GENERAL**

- Chills
- Fever
- Sweats
- Fatigue
- Weight Loss
- Eyes
- Loss of vision
- Double vision
- Blurred Vision
- Eye pain
- Wear glasses/contacts

**ENT**

- Hearing loss right
- Hearing loss left
- Hearing loss both ears
- Hearing aids right
- Hearing aids left
- Hearing aids both ears
- Ear pain right
- Ear pain left
- Ear pain both ears
- Ear drainage right
- Ear drainage left
- Ear drainage both ears
- Ringing in ear right
- Ringing in ear left
- Ringing in ear both
- Nosebleeds right
- Nosebleeds left
- Nosebleeds bilateral
- Snoring
- Nasal congestion
- Nasal drainage/discharge
- Loss of smell
- Dental pain/problems
- Mouth Sores
- Sore throat
- Hoarseness/voice change
- Difficulty Swallowing

**CARDIOVASCULAR**

- Chest pain/discomfort
- Shortness of breath with exertion
- Palpitations
- Swelling hands/feet

**RESPIRATORY**

- Cough
- Shortness of breath
- Coughing blood
- Wheezing

**GASTROINTESTINAL**

- Heartburn/reflux
- Vomiting blood
- Nausea/vomiting
- Abdominal pain

**GENITOURINARY**

- Trouble starting/stopping urination
- Painful urination
- Bloody urine

**MUSCULOSKELETAL**

- Arthritis
- Arm pain
- Back pain
- Leg pain
- Joint Swelling
- Joint pain

**SKIN**

- Suspicious lesions
- Poor wound healing
- Skin cancer
- Rash

**NEUROLOGIC**

- Sensation of room spinning
- Poor balance
- Headaches
- Loss of coordination
- Numbness

- Speech difficulty
- Falling down
- Seizures
- Fainting
- Psychiatric
- Anxiety
- Depression
- Mental problems
- Suicidal thoughts

**ENDOCRINE**

- Cold intolerance
- Heat intolerance
- Excessive hunger
- Excessive thirst

**HEME/LYMPHATIC**

- Enlarged lymph nodes
- Easy bleeding or bruising
- Blood transfusion
- Cancer
- Anemia

**ALLERGIC/IMMUNOLOGIC**

- Seasonal allergies
- Hives or rash
- Food allergies
- HIV exposure