

Name _____ Sex M F Age ____ Weight ____ Height _____

Family Dr. Name: _____ Other relevant Specialists/Drs.: _____

CHIEF COMPLAINT: (What is the main reason for your visit?) _____

How long have you had this problem? _____

REVIEW OF SYSTEMS: (Please answer Yes or No to each symptom)

Fever/Night Sweats/Weight Loss	Y	N	Swollen Joints	Y	N
Visual Disturbances	Y	N	Skin Rash/Itching	Y	N
Hearing Loss	Y	N	Balance Problems/Tremors/Dizziness	Y	N
Ringing in the Ears	Y	N	Confusion/Depression	Y	N
Chest Pain	Y	N	Dry Skin	Y	N
Shortness of Breath	Y	N	Bleed or Bruise Easily	Y	N
Throat Problems	Y	N	Allergic/Immune Problems	Y	N
Nasal Problems	Y	N	Heartburn/Nausea/Vomiting/Abdominal Pain	Y	N
Urinary Problems	Y	N			

PAST MEDICAL HISTORY: (Please circle all that apply to you)

Diabetes	Asthma	Ulcers	Noise Exposure
High Blood Pressure	Pneumonia (When? _____)	Reflux	
Heart Attack	Tuberculosis	Hiatal Hernia	
Heart Rhythm Problems	Emphysema/COPD	Liver Disease	
Mitral Valve Prolapse	Anemia	Hepatitis	
Congestive Heart Failure	Seizures	Thyroid Disorder	
Vascular Disease	Arthritis	Cancer	
Rheumatic Fever	Glaucoma	HIV Exposure/AIDS	
Stroke	Kidney Problems	Radiation/Chemotherapy	

Please list any other serious medical problems: _____

SLEEP APNEA? Y N Have you had a **Sleep Study?** Y N **CPAP?** Y N

Name of Doctor who did your Sleep Study? _____ Sleep Study Date? _____

ALLERGY TESTING? Y N When? _____ Name of allergy Dr. _____

List what was Positive _____

PAST SURGICAL HISTORY - Have you ever had surgery of any kind before? Y N

Please list any surgery you have had: _____

Have you had previous problems with anesthesia? Y N

If so, please describe: _____

Bleeding Problem: Do you bruise easily or bleed excessively when cut? Y N

Female Patients: Are you Pregnant? Y N Using Birth Control? Y N Breast Feeding? Y N

DRUG ALLERGY? Y N List drugs: _____

Describe drug reaction: _____

LATEX ALLERGY? Y N

Describe latex reaction: _____

MEDICATIONS

Please LIST all current **prescription** and **over-the-counter MEDICATIONS** (including dosage, length of time you have taken and the reason you take the medication):

<u>Medication Name</u>	<u>Dosage</u>	<u>Reason for Taking</u>	<u>How long have you taken?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you taking any supplements or herbal medications? Y N If Yes, circle below:

- | | | | |
|-----------|-----------------|-----------------|-------------|
| Vitamin E | St. John's Wort | Feverfew | Other _____ |
| Garlic | Ginko Biloba | FishOil/Omega 3 | |
| Ephedra | Ginseng | Ginger | |

SOCIAL HISTORY

Do you use tobacco? Y N Cigars Cigarettes Smokeless
 How much per day? _____ How long? _____

Have you ever used tobacco in past? Y N How long? _____ When did you quit? _____

Do you use alcohol? Y N How often? _____ How much? _____

Do you use recreational drugs? Y N If so, please list: _____

What is your occupation? (If retired, list former occupation.) _____

FAMILY HISTORY

Are you married? Y N

Do you have a family history of:

Hearing Loss	Y	N
Malignant Hyperthermia (High Temperature after surgery)	Y	N
Muscle Disease	Y	N
Cancer	Y	N
Diabetes	Y	N
Heart Disease	Y	N
Complications with Anesthesia	Y	N
Bleeding Disorder	Y	N

Pediatric History (For patients age: 0 - 12 years only)

Birth Weight: _____ Please provide details below if YES

C-Section? Y N

Premature? Y N _____

Problems with Pregnancy? Y N _____

Problems at Birth? Y N _____

Apnea? Y N _____

Monitored? Y N _____

Failed newborn hearing screening? Y N _____

Following blanks are for Physician completion only:

Reviewed by Physician _____

PHYSICIAN UPDATE FOR SURGERY MUST BE WITHIN 30 DAYS PRIOR TO SURGERY DATE.

Physician Reviewed and Updated: _____

Date

Physician Signature