



\_\_\_\_\_

\_\_\_\_\_

Please describe what kind of procedure you are interested in having: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you consulted with other physicians about procedure(s) indicated above: No Yes

If Yes, please describe your understanding of the procedure(s) \_\_\_\_\_

Is this procedure a revision from a previous surgery No Yes If yes, how many previous surgeries? \_\_\_\_\_

What is your "ideal time frame" for procedure(s) completion \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**Primary Insurance Co (if applicable)** \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Name of person insured \_\_\_\_\_ SS# \_\_\_\_\_

Eligibility Phone # \_\_\_\_\_ Copay \_\_\_\_\_

**Secondary Insurance Co.** \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Name of person insured \_\_\_\_\_ SS# \_\_\_\_\_

Eligibility Phone # \_\_\_\_\_ Copay \_\_\_\_\_

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### HEALTH INFORMATON

Personal Past History:

Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure  
Heart Disease  
Heart Failure  
Seizures  
Heart Attack  
Chest Pain

Diabetes  
Kidney Disease  
Psychiatric Diagnosis  
Bleeding Problems  
Liver Disease  
Gastric Reflux  
Asthma

Cancer  
HIV or AIDS  
Stroke  
Hepatitis  
Emphysema  
Stomach Problems  
Other \_\_\_\_\_

Is there a personal or family history of anesthetic complications? No Yes

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Family History:

Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

High Blood Pressure  
Heart Disease  
Heart Failure  
Seizures  
Heart Attack  
Chest Pain

Diabetes  
Kidney Disease  
Psychiatric Diagnosis  
Bleeding Problems  
Liver Disease  
Gastric Reflux  
Asthma

Cancer  
HIV or AIDS  
Stroke  
Hepatitis  
Emphysema  
Stomach Problems  
Other \_\_\_\_\_

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Please list all prior operations:

Date

List any complications

- |          |       |       |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |

Please list all prior Hospitalizations:

Date

List any complications

- |          |       |       |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
- 

Please list ALL medications and/or dietary supplements including:

**(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)**

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



Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure Y \_\_\_ N \_\_\_  
Heart Attack Y \_\_\_ N \_\_\_  
Angina/chest pain Y \_\_\_ N \_\_\_  
Heart bypass surgery Y \_\_\_ N \_\_\_  
Pacemaker Y \_\_\_ N \_\_\_

Heart Failure Y \_\_\_ N \_\_\_  
Irregular Heartbeat Y \_\_\_ N \_\_\_  
Heart Murmur Y \_\_\_ N \_\_\_  
Do you exercise? Y \_\_\_ N \_\_\_  
Comments: \_\_\_\_\_

NEUROLOGICAL

Stroke Y \_\_\_ N \_\_\_  
Seizures Y \_\_\_ N \_\_\_  
Fainting Y \_\_\_ N \_\_\_  
Dizziness Y \_\_\_ N \_\_\_  
Headache Y \_\_\_ N \_\_\_  
Double Vision Y \_\_\_ N \_\_\_

RESPIRATORY

Abnormal Chest X-ray Y \_\_\_ N \_\_\_  
Asthma Y \_\_\_ N \_\_\_  
Bronchitis Y \_\_\_ N \_\_\_  
Emphysema Y \_\_\_ N \_\_\_  
Recent Chest Infection Y \_\_\_ N \_\_\_  
Shortness of Breath Y \_\_\_ N \_\_\_  
Shortness of Breath at night Y \_\_\_ N \_\_\_  
Shortness of Breath on exertion Y \_\_\_ N \_\_\_  
Cough Y \_\_\_ N \_\_\_  
Cough with Sputum Y \_\_\_ N \_\_\_  
Sleep Apnea Y \_\_\_ N \_\_\_  
-Use a C-PAP Machine Y \_\_\_ N \_\_\_

PSYCHIATRIC

Depression Y \_\_\_ N \_\_\_  
Anxiety Y \_\_\_ N \_\_\_  
Psychiatric Care Y \_\_\_ N \_\_\_  
Obsessive Compulsive Disorder Y \_\_\_ N \_\_\_

MUSCULOSKELETAL

Sciatica Y \_\_\_ N \_\_\_  
Herniated disc Y \_\_\_ N \_\_\_  
Arthritis Y \_\_\_ N \_\_\_  
Rheumatoid Y \_\_\_ N \_\_\_  
Neck, Back, Arm, Leg Prob Y \_\_\_ N \_\_\_

ENDOCRINE

Diabetes Y \_\_\_ N \_\_\_  
Thyroid Disease Y \_\_\_ N \_\_\_  
Taken Steroids Y \_\_\_ N \_\_\_

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency Y \_\_\_ N \_\_\_  
Easy Bruising Y \_\_\_ N \_\_\_  
Anemia Y \_\_\_ N \_\_\_  
Sickle Cell Disease Y \_\_\_ N \_\_\_  
Blood clots in legs Y \_\_\_ N \_\_\_  
Blood clots in lungs Y \_\_\_ N \_\_\_  
Radiation Therapy Y \_\_\_ N \_\_\_

INFECTIOUS

GASTROINTESTINAL

Jaundice Y \_\_\_ N \_\_\_  
Hepatitis Y \_\_\_ N \_\_\_  
Ulcers Y \_\_\_ N \_\_\_  
Hiatal Hernia Y \_\_\_ N \_\_\_  
Heartburn Y \_\_\_ N \_\_\_

URINARY/REPRODUCTIVE

Kidney Disease Y \_\_\_ N \_\_\_  
Urinary Disease Y \_\_\_ N \_\_\_  
Dialysis Y \_\_\_ N \_\_\_  
If Female, could you be preg? Y \_\_\_ N \_\_\_  
Number of live births \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_  
Date of last mammogram \_\_\_\_\_  
Date of date of menses (period) \_\_\_\_\_

SKIN

Basal cell skin cancer Y \_\_\_ N \_\_\_  
Melanoma Y \_\_\_ N \_\_\_  
Staph Infection Y \_\_\_ N \_\_\_

EYES

Cataracts Y \_\_\_ N \_\_\_  
Glaucoma Y \_\_\_ N \_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned have read this document and the information provided in this document is true.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date