



I attest that the information contained in this form is a complete and accurate reflection of my current health status and medical history.

Signature Date

Name _____
Last First Middle

Address _____ Apt. # _____

City _____ State _____ Zip _____

Phone number _____ May we text this phone number? _____

Email _____ May we email this address? _____

Age _____ Birthdate _____ Social Security # (last 4 digits) _____

Female _____ Male _____ Marital Status _____ Employer/Occupation _____

Reason for Visit _____

Referred By _____

Family Physician _____

Emergency Contact _____

Relationship to Patient _____ Phone # _____

Preferred Pharmacy Name and Location _____

Current Medications (Dose and Frequency - continue on back as necessary)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Do you take vitamins, herbal supplements, or diet pills? _____

Do you take aspirin, NSAIDS, MOA inhibitors or blood thinners? _____

Do you have any of the following medical conditions?

- Latex Allergy Sleep Apnea Diabetic Insulin Pump Pacemaker Defibrillator Home Oxygen
- Anticoagulants MRSA VRE C-Diff HIV Hepatitis C None of these

Allergies No Yes (please list all) _____

Height _____ Weight _____

Social History

Tobacco/ Nicotine No Yes How much? _____ Former _____ Quit: _____

Alcohol No Yes Number of drinks per day/week _____

Drug Use No Yes Type/frequency: _____



Medical History (Please check ALL that apply with details below)

<input type="checkbox"/> Breast Cancer <input type="checkbox"/> Breast Lumps <input type="checkbox"/> Breast Pain <input type="checkbox"/> Breast Asymmetry <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Other Breast <input type="checkbox"/> _____ <input type="checkbox"/> None of the above	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Anemia <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Bruising (easily) <input type="checkbox"/> Transfusions <input type="checkbox"/> Enlarged Lymph Nodes <input type="checkbox"/> Other Endocrine/Lymphatic <input type="checkbox"/> _____ <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Failure <input type="checkbox"/> Pacemaker/Defibrillator <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Other Cardiovascular <input type="checkbox"/> _____ <input type="checkbox"/> None of the above
<input type="checkbox"/> Skin Cancer <input type="checkbox"/> Melanoma <input type="checkbox"/> Changing Lesion <input type="checkbox"/> Other Dermatologic <input type="checkbox"/> _____ <input type="checkbox"/> None of the above	<input type="checkbox"/> Pulmonary Embolism/DVT <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Other Respiratory <input type="checkbox"/> _____ <input type="checkbox"/> None of the above	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Other Psychiatric <input type="checkbox"/> _____ <input type="checkbox"/> None of the above

Medical History Additional Information (diagnoses, dates, treatments)

Previous Surgical History (Procedure/Surgeon/Date)

Family Medical History (including cancer, heart history, blood clots/pulmonary embolism)

Female Patients

Date of Last Mammogram _____ Location _____ Result _____

Method of birth control _____ Number of Births _____ Number of Pregnancies _____

Could you be pregnant now? _____ Are you attempting pregnancy? _____

OFFICE USE ONLY PCP PREOP ANESTHESIA PREOP _____