

Patient Name _____ **Date of Birth / Age** _____ **Today's Date** _____

Surgeries: Please list any surgeries you have had in the past (ex. Lasik eye, tonsils, gallbladder, hysterectomy, wisdom teeth, etc.). Please list any cosmetic surgeries as well (please use an extra sheet if needed):

Surgery Type	Year	Surgery Type	Year

Do you have any history of anesthesia problems with surgery? No Yes (if yes, please explain):

Medical History: For what medical or mental conditions have you previously been or are currently being treated? (please check all that apply, use an extra sheet if more "details" are needed):

	Yes	Details		Yes	Details
- Pt denies any past medical history			High Cholesterol		
Acid Reflux/GERD			HIV/AIDS		
ADD/ADHD			Kidney Failure		
Anxiety/Depression			Lasik Surgery		
Arthritis			Leukemia		
Artificial Joints			Neck Pain		
Back Pain			Neurologic - Seizures		
Bleeding/Blood Disorders			Neurologic - Stroke/TIA		
Breast Cancer			Prostate Disease/Cancer		
Cancer			Prosthetic Device (Implants)		
Chemotherapy			Radiation		
Cold Sores/Herpes			Respiratory - Asthma		
Diabetes - Diet control			Respiratory - COPD		
Diabetes - Medication control			Respiratory - other		
Diabetes - Insulin dependent			Skin Cancer - Basal Cell		
Fibromyalgia/Chronic Fatigue			Skin Cancer - Melanoma		
Headaches/Migraines			Skin Cancer - Squamous Cell		
Hearing Loss			Skin Disease/Disorder		
Heart Disease - Arrhythmia/A-Fib			STD		
Heart Disease - history MI			Substance Abuse		
Heart Disease - other			Thyroid Disorder		
Heart Disease - Pacemaker/Defib			Tuberculosis		
Heart Disease - stents			Ulcers		
Heart Murmur/MVP			OTHER -		
Hepatitis			OTHER -		
High Blood Pressure			OTHER -		

Patient Name

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Social History:

Alcohol	<input type="checkbox"/>	Denies alcohol use
	<input type="checkbox"/>	Admits alcohol use socially
	<input type="checkbox"/>	Admits alcohol use daily
	<input type="checkbox"/>	Recovering alcoholic
Illegal Drugs	<input type="checkbox"/>	Denies using illegal drugs
	<input type="checkbox"/>	Admits to using illegal drugs
Tobacco	<input type="checkbox"/>	Denies tobacco use
	<input type="checkbox"/>	Tobacco smoker
	<input type="checkbox"/>	Smokeless tobacco user (i.e. chew, snuff)
	<input type="checkbox"/>	Tobacco use unknown, reason not specified

Height _____

Current Weight _____

If you are being seen for a lesion, mole or skin cancer, please fill out the following:

Lesion / Skin Cancer:

Size: _____ Present How Long? _____

Location / Site: _____

When did symptoms start? _____

How has it changed? _____

Biopsy done? _____ What doctor? _____

Sun exposure? _____ History of skin cancer: _____