Patient Name:	DOB:	Age:	Height:	Weight:

Purpose/Goal of today's visit:

Have you consulted with other doctors regarding this concern? ☐ Yes ☐ No (*If yes, please list the doctor's name)*:

Have you had any previous surgeries to address this concern? ☐ Yes ☐ No (*If yes, when)*:

MEDICAL HISTORY

Do you have any allergies to food and/or medications? ☐ Yes ☐ No

(*Please check box below indicating Allergy or Reaction to what type of food or medication, and please provide details on your experience*):

Medical Allergy	Adverse Reaction	Name of Medication or type of food	Please describe in detail the nature of the allergy and/or the type of reaction, and on what occasion(s) did the reaction occur:
☐	☐		
☐	☐		
☐	☐		

List any medications you are currently taking (*Include OTC medications, supplements, vitamins, etc.*):

Medication	Strength	# per day	Medication	Strength	# per day
1)			4)		
2)			5)		
3)			6)		

List any prior surgeries you have undergone in the past:

Surgery	Date of Surgery

Have you ever experienced any complications related to anesthesia? ☐ Yes ☐ No (*If yes, please specify below*):

☐ Post-op nausea/vomiting ☐ Intra-Op Recall ☐ Slow to wake ☐ Malignant Hyperthermia ☐ Other

Have you ever experienced complications related to a previous surgery? ☐ Yes ☐ No (*If yes, please specify)*:

Are you currently, or have you in the past, received psychiatric assistance? ☐ Yes ☐ No

(*If yes, please list name and address of psychiatrist or psychologist*):

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Patient Name: _____ Date: _____

Please check any of the following that apply:

☐ Yes ☐ No Smoke Cigarettes ☐ I smoke _____ (Amount/Day)
☐ Yes ☐ No Smoke Marijuana ☐ Daily ☐ _____ times/week ☐ Other)
☐ Yes ☐ No Vape ☐ Daily ☐ _____ times/week ☐ Ocassionally)

☐ **I quit smoking on** ___ ___ ___
☐ **I last smoked on** ___ ___ ___
☐ **I last vaped on** ___ ___ ___

Have you had any adverse reactions to the following? (*Please circle any of the following that apply*)

☐ Yes ☐ No Local Anesthetics (Lidocaine, Epinephrine)
☐ Yes ☐ No Skin Disinfectants (Betadine, Chlorohexidine)
☐ Yes ☐ No Adhesive Tape
☐ Yes ☐ No Pain Medications (*Please specify):* _____
☐ Yes ☐ No Antibiotics (*Please specify):* _____

Do you currently have, or have you had in the past, a history of any of the following? (*Check all that apply*)

Cardiovascular:
- ☐ Abnormal Heart Rhythm
- ☐ Anemia/Bleeding Disorder
- ☐ Blood Clot
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Irregular EKG
- ☐ Low Blood Pressure
- ☐ Problem with Circulation
- ☐ Stroke
- ☐ Use Blood Thinners: _____

Respiratory:
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis –
  Use of steroids? ☐ Yes ☐ No
  Use of nonsteroidals? ☐ Yes ☐ No
- ☐ COVID-19 Vaccinated? ☐ Yes ☐ No
  If yes, manufacturer: _____
- ☐ Emphysema
- ☐ Require CPAP/BIPAP for Sleep
- ☐ Pneumonia
- ☐ Shortness of Breath At Rest
- ☐ Sleep Apnea
- ☐ Unproductive Cough

Diabetes:
- ☐ Oral Hypoglycemia
- ☐ Type I
- ☐ Type II
- ☐ Use Insulin
- ☐ Use Insulin Pump
- ☐ Well Controlled

Neurological Disorder:
- ☐ Chronic Neck/Back Pain
- ☐ Multiple Sclerosis
- ☐ Nerve/Spinal Cord Injury
- ☐ Neuropathy
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke

Gastro-Intestinal/Genitourinary:
- ☐ GERD/Acid Reflux
- ☐ Frequent Urinary Tract Infections
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Irregular Bowel Movements

Gyn/General Surgery:
- ☐ History of Pregnancy
  Number of Births ____
  Breastfed ☐ Y ☐ N
- ☐ History of Procedure:
- ☐ Hernia
- ☐ C-Section
- ☐ Laparoscopy
- ☐ Cholecystectomy
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Date of Last Mammogram
  ____ / ____ / ____
- ☐ Date of Last Menstrual Period
  ____ / ____ / ____

Miscellaneous:
- ☐ ADHD
- ☐ Anxiety
- ☐ Autoimmune Disease
- ☐ Cancer (Personal History)
- ☐ Cancer (Family History)
- ☐ Cold Sores
- ☐ Depression
- ☐ Dry Eyes
- ☐ Environmental Allergies
- ☐ Scars (Keloid/Hypertrophic)
- ☐ Lasik
- ☐ Problems with Wound Healing
- ☐ Skin Disorders
- ☐ Problems with Anesthesia
- ☐ Other _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____