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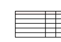
Patient History

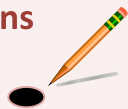
Please answer every question


STAFF: Handwritten responses must be entered **MANUALLY**.

PLEASE PRINT PATIENT'S LAST NAME

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Please mark all surgeries you have had.

○ **I have had NO Surgeries.** *(Skip to next page.)*

○ **Anal Fissure Repair**	○ **Appendectomy**	○ **Hemorrhoidectomy**	○ **Vasectomy**
○ **Sinus Surgery**	○ **Tonsillectomy**	○ **Bariatric Surgery**	○ **Ulcer Surgery**
○ **Plastic / Reconstruction**	○ **Deviated Nose Septum**	○ **Removal of Skin Cancer**	○ **Skin Grafting**

Prostate Surgery	○ TURP	○ Removal		
Colon Polyp Removal	○ Open	○ Colonoscopy		
Colon Removal	○ Partial	○ Complete		
Low Back Disc Surgery	○			
Spinal Fusion	○ Neck	○ Lower Back		
Spinal Decompression	○ Neck	○ Lower Back		
Carpal Tunnel Surgery	○ Left	○ Right	○ Both	
Rotator Cuff Repair	○ Left	○ Right	○ Both	
Arthroscopic Shoulder Surgery	○ Left	○ Right	○ Both	
Hip Fracture & Surgery	○ Left	○ Right	○ Both	
Total Hip Replacement	○ Left	○ Right	○ Both	
Arthroscopic Knee Surgery	○ Left	○ Right	○ Both	
Total Knee Replacement	○ Left	○ Right	○ Both	
Foot Surgery	○ Left	○ Right	○ Both	
Amputation	○ Leg	○ Foot	○ Both	
Defibrillator / Pacemaker	○			
Dialysis Access	○			
Venous Life Port	○			
Carotid Artery Surgery	○ Left	○ Right	○ Both	○ Multiple times
Heart Valve Replacement	○ Mitral	○ Aortic	○ Tricuspid	○ Unknown Valve
Heart Bypass Surgery	○ 1 vessel	○ 2 vessels	○ 3 vessels	
	○ Unknown number of vessels		○ 4 or more vessels	
Leg Circulation Surgery	○ Left	○ Right	○ Both	
Tubal Ligation	○			
Hysterectomy (due to cancer)	○ Partial	○ Complete		
Hysterectomy (not due to cancer)	○ Partial	○ Complete		
Dilation and Curettage (D&C)	○ Single	○ Multiple		
Breast Biopsy	○ Left	○ Right	○ Both	○ Multiple times
Breast Cancer Lump Removal	○ Left	○ Right	○ Both	
Mastectomy	○ Left	○ Right	○ Both	
Breast Reconstruction	○ Left	○ Right	○ Both	
Breast Reduction	○ Left	○ Right	○ Both	
Ovary Removal	○ Left	○ Right	○ Both	
Caesarean Section	○ 1	○ 2	○ 3 or more	
Umbilical / Ventral Hernia	○			
Abdominal Aortic Aneurysm	○			
Laparoscopic Inguinal Hernia Surgery	○ Left	○ Right	○ Both	○ Multiple times
Open Inguinal Hernia Surgery	○ Left	○ Right	○ Both	○ Multiple times
Kidney Removal	○ Left	○ Right	○ Both	
Lung Surgery	○ Left	○ Right	○ Both	
Cataract Surgery	○ Left	○ Right	○ Both	
Thyroid Removal	○ Left	○ Right	○ Both	○ Partial
Gallbladder Surgery	○ Open	○ Laparoscopic		

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

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SAMPLE

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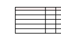

STAFF: Handwritten responses must be entered **MANUALLY**.

IMMUNIZATION RECORD

Please indicate the year of your last dose for each of the following.

Pneumonia ________________________ **Tetanus** ________________________
Hepatitis ________________________ **Shingles** ________________________

ALLERGIES

Please indicate any known allergies you have.

Name of Allergy	Type of Reaction

MEDICATIONS

Please list all medications you are currently taking.

Include prescriptions (pills, inhalers, creams, shots), over the counter medication (aspirin, antacids, etc.), vitamins and supplements (fish oil, etc). Include medications that you use only as needed.

Name of Medication	Dose (strength)	Directions (how often do you take it)

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

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