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Patient History

Please answer every question

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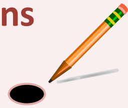
Marking Instructions

Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

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.)*

- ○ Umbilical / Ventral Hernia
- ○ Abdominal Aortic Aneurysm
- ○ Plastic / Reconstruction
- ○ Heart Valve Replacement
- ○ Defibrillator / Pacemaker
- ○ Vasectomy
- ○ Tubal Ligation
- ○ Hemorrhoidectomy
- ○ Removal of Skin Cancer
- ○ Low Back Disc Surgery
- ○ Appendectomy
- ○ Tonsillectomy
- ○ Deviated Nose Septum
- ○ Dialysis Access
- ○ Venous Life Port
- ○ Ulcer Surgery
- ○ Sinus Surgery
- ○ Bariatric Surgery
- ○ Anal Fissure Repair
- ○ Skin Grafting

Surgery				
Prostate Surgery	○ TURP	○ Removal		
Colon Removal	○ Partial	○ Complete		
Carpal Tunnel Surgery	○ Left	○ Right	○ Both	
Shoulder Surgery	○ Left	○ Right	○ Both	
Hip Surgery	○ Left	○ Right	○ Both	
Knee Surgery	○ Left	○ Right	○ Both	
Foot Surgery	○ Left	○ Right	○ Both	
Amputation	○ Leg	○ Foot	○ Both	
Carotid Artery Surgery	○ Left	○ Right	○ Both	○ Multiple times
Heart Surgery	○ 1 vessel	○ 2 vessels	○ 3 vessels	
	○ Unknown number of vessels		○ 4 or more vessels	
Leg Circulation Surgery	○ Left	○ Right	○ Both	
Hysterectomy	○ Partial	○ Complete		
Dilation and Curettage (D&C)	○ Single	○ Multiple		
Breast Biopsy	○ Left	○ Right	○ Both	○ Multiple times
Breast Lump Removal	○ Left	○ Right	○ Both	
Mastectomy	○ Left	○ Right	○ Both	
Breast Reconstruction	○ Left	○ Right	○ Both	
Breast Reduction	○ Left	○ Right	○ Both	
Caesarean Section	○ 1	○ 2	○ 3 or more	
Inguinal Hernia Surgery	○ Left	○ Right	○ Both	○ Multiple times
Kidney Removal	○ Left	○ Right	○ Both	
Lung Surgery	○ Left	○ Right	○ Both	
Cataract Surgery	○ Left	○ Right	○ Both	
Thyroid Surgery	○ Left	○ Right	○ Both	○ Partial
Gallbladder Surgery	○ Open	○ Laparoscopic		

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Patient History

Please answer every question

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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)

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