

Patient History & Physical

Date: _____ Name: _____ Date of Birth: _____ Diagnosis: _____

Planned Surgery: _____

Indication(s) For Surgery: _____

Primary Care Doctor: _____ Date of Last Complete Check-up: _____

Health History:

Explanation:

- _____ Cancer _____
- _____ Stroke/TIA _____
- _____ Diabetes _____
- _____ Chest Pain/MI _____
- _____ Heart Problems _____
- _____ High Blood Pressure _____
- _____ High Cholesterol _____
- _____ Blood Clots _____
- _____ Hepatitis/Jaundice _____
- _____ Headaches _____
- _____ Rheumatoid/Lupus/Psoriasis _____
- _____ Gout/Pseudogout _____
- _____ Osteoporosis _____
- _____ Asthma/COPD/Sleep Apnea _____
- _____ Recent Cold/Bronchitis _____
- _____ Anemia _____
- _____ Thyroid Problems _____
- _____ Mental Illness/Depression _____
- _____ Seizures/Epilepsy _____
- _____ Syncope/Vertigo _____
- _____ Kidney/Bladder Problems _____
- _____ Bleeding Disorder _____
- _____ Sickle Cell Disease/Trait _____
- _____ Stomach Trouble/Ulcers _____
- _____ Skin Problems _____
- _____ Prior Blood Transfusion _____
- _____ Transfusion Reaction _____
- _____ Arthritis _____
- _____ Glaucoma/Cataracts _____
- _____ Positive TB Test - When _____ Last Tested _____
- _____ HIV/AIDS _____
- _____ Immune Disorder _____
- _____ Prior Anesthesia Problems _____
- _____ Recent Exposure to Measles/Mumps/Chicken Pox (14 days) _____
- _____ Disabilities/Limitations _____
- _____ Possibly Pregnant _____ Date of LMP: _____

Latex Allergy: Yes No

Medicine Allergies: _____

Food Allergies: _____

Daily Aspirin Use: Yes No

Medicines Taken - Dosages & Frequency: _____

Prior Surgeries with Dates: _____

Tobacco Use: _____ PPD for _____ Years

Quit Smoking When: _____

How Long Did You Smoke: _____

Alcohol Use: _____ Drinks/Day

History of Alcoholism: Yes No

Recreational Drug Use: Yes No

Please List: _____

Children – Immunizations UTD: Yes No

Birth Defects: _____

Review Of Systems (Recent): _____ Contact Lenses/Glasses _____ Weight Change _____ Fever/Chills/Sweats _____ Headaches

_____ Shortness of Breath _____ Chest Pain _____ Fatigue _____ Insomnia _____ Fainting _____ Rash _____ Sinus Pain

_____ Skin/Hair/Nail Changes _____ Vision Changes _____ Cough/Wheezing _____ Sinus Pain _____ Bloody Stool/Urine/Sputum

Family Medical History: _____

Physical Exam: Pulse: _____ Temperature: _____ Blood Pressure: _____ Weight: _____

HEENT: _____ Neck: _____ Lungs: _____

Cardiac: _____ Abdomen: _____ Rectal/Genitalia: _____

Physician's Signature: _____ Date: _____