Surgery Patient Database: Date: _____

Name: Date of Birth:

Age: ☐ Male ☐ Female

Date of injury _____

Allergies Check Box if you have No Known Drug Allergies: ☐

☐ Penicillin
☐ Sulfa
☐ Aspirin
☐ Codeine
☐ Morphine
☐Demerol
☐ Anesthesia
☐ Iodine or seafood
☐ LATEX, banana, kiwi, avocado, chestnuts
☐ Tape
☐ others

Medications *List all prescriptions

Medication	Dosage	Frequency

Taken steroids (prednisone) in the last 12 months ☐ Yes ☐ No

Taking ☐ Coumadin ☐ Plavix ☐ Birth Control Pills

Non prescription medicines and other products

Last time you took aspirin?

Last time you took Motrin, Advil, ibuprofen

Other over-the-counter medicine

Check box if you take:

☐ St. John's Wort (increases narcotic & anesthetic effects)

☐ Gingko Biloba ☐Garlic ☐ Feverview ☐ Fish oil (bleeding: antiplatelet)

☐ Ginseng (causes hypertension & tachycardia)

☐ Vitamin E (antiplatelet & delays wound healing)

PAST MEDICAL HISTORY

Do you have…

Heart Problems?	☐ No ☐ Yes	Describe:	☐ Coronary Disease/blockages ☐ Angina ☐ Heart Attack ☐ Congestive Heart Failure ☐ Valve problem or murmur
High blood pressure?	☐ No ☐ Yes		
High Cholesterol?	☐ No ☐ Yes		
Stroke?	☐ No ☐ Yes	Describe:	☐ Mini-strokes/TIA ☐ Stroke
Lung Problems?	☐ No ☐ Yes	Describe	☐ Asthma ☐ Emphysema ☐ Pneumonia ☐ Bronchitis
Diabetes?	☐ No ☐ Yes	Describe	☐ insulin controlled ☐ Pill/Diet controlled
Digestive Problems?	☐ No ☐ Yes	Describe	☐ Hiatal Hernia ☐ Reflux ☐ Gall Stones ☐ Ulcer ☐ Jaundice ☐ Hepatitis ☐ Diverticulosis/Diverticulitis ☐ Pancreatitis ☐ Hemorrhoids ☐ Irritable Bowel Syndrome ☐ Crohn's ☐ Ulcerative Colitis
Kidney Problems?	☐ No ☐ Yes	Describe	☐ Kidney Stones ☐ Dialysis
Cancer?	☐ No ☐ Yes	Describe	Type:

Additional problems (check if yes)

☐ Anemia ☐ Arthritis ☐ Anxiety/Depression ☐ Alcohol dependency
☐ Back problems ☐ Epilepsy ☐ Glaucoma ☐ Gout ☐ Herpes ☐ HIV
☐ Migraines ☐ Osteoporosis ☐ Prostate ☐ Shingles ☐ TB ☐ Thyroid
Others:

List all Operations, Surgeon and year

☐ Appendix	☐ Breast Biopsy
☐ Gall Bladder	☐ Mastectomy
☐ Thyroid	☐ Angioplasty
☐ Ulcer operation	☐ carotid Endarterectomy
☐ Hernia	☐ Coronary Artery bypass
☐ Hysterectomy	☐ Heart Valve
☐ Prostate	☐ Pacemaker or ICD

Others:

FAMILY HISTORY

	Age	Living	Deceased	Medical Problems or cause of death
Father				
Mother				
Brothers/Sisters				

SOCIAL HISTORY

Your Occupation	☐ working ☐ retired
Do you smoke cigarettes? ☐ Yes ☐ No ☐ Quit Packs per day: Years	
Do you drink alcohol? ☐ Never ☐ Socially ☐ Daily/How much?	
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Religion	
Do you have a living will or other advance directive? ☐ Yes ☐ No	

REVIEW OF SYSTEMS

Do you have ….. (please answer each)			**Physician's use only**
Dizziness, Vertigo?	☐ YES	☐ NO	(ENT) 1 vestib sx
Difficulty swallowing?	☐ YES	☐ NO	2 dysphagia
Chest Pain or pressure?	☐ YES	☐ NO	(CARDIOVASCULAR) 3 angina
Leg cramps when walking?	☐ YES	☐ NO	4 claudication
Hard to breathe if you lay flat?	☐ YES	☐ NO	(PULMONARY) 5 orthopnea
Hard to breathe after a flight of stairs?	☐ YES	☐ NO	6 D.O.E
Severe Heartburn or indigestion?	☐ YES	☐ NO	(GI) 7 Reflux
Rectal bleeding: bloody, black or tarry stools?	☐ YES	☐ NO	8 hematochezia or melena
Painful to urinate?	☐ YES	☐ NO	(GU) 9 dysuria
Blood in urine?	☐ YES	☐ NO	10 hematuria
Muscle pain? (chronic)	☐ YES	☐ NO	(MUSCULOSKELETAL) 11 myaligias
Joint pain? (chronic)	☐ YES	☐ NO	12 arthralgias
Rashes, sores, ulcers which won't heal?	☐ YES	☐ NO	(INTEGUMENTARY) 13 chronic lesions
Moles which have changed appearance?	☐ YES	☐ NO	14 changing lesions
Seizures?	☐ YES	☐ NO	(NEUROLOGIC) 15 seizures
Weaken or paralyzed limbs?	☐ YES	☐ NO	16 paralysis
Frequent nosebleeds?	☐ YES	☐ NO	(HEMATOLIGIC) 17 epistaxis
Trouble stopping bleeding	☐ YES	☐ NO	18 coagulopathy
Major fatigue?	☐ YES	☐ NO	(CONSTITUTIONAL) 19 lethargy
Unplanned weight loss?	☐ YES	☐ NO	20 Wt loss

Your answers will aid in making a comprehensive surgical evaluation: Thanks you for your time & effort!

Patient Signature Date