CENTER FOR MINIMALLY INVASIVE SURGERY

PATIENT MEDICAL, FAMILY AND SOCIAL HISTORY

PATIENT NAME:_____ DATE:_____

DATE OF BIRTH:_____AGE_____

WHY ARE YOU HERE TODAY?_____

PAST OR CURRENT ILLNESSES: PLEASE CIRCLE AND EXPLAIN = N/A

HIGH BLOOD PRESSURE	CANCER	ULCERS	BLOOD OR BLEEDING-DISORDER
CHOLESTEROL	ASTHMA	EPILEPSY	EMOTIONAL PROBLEMS-DEPRESSION
HEART PROBLEMS	TUMORS	RHEUMATIC FEVER	
DIABETES	HEPATITIS		

(explanation)_____

_____

_____

HOSPITALIZATIONS/SURGERIES/ACCIDENTS = DESCRIBE THE NATURE OF THE PROBLEM AND THE APPROX YR.= N/A

_____ _____ _____

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS: SEE NEXT PAGE ➡ **OR IF NO MEDS/CHECK THIS BOX [ ]**

HAVE YOU HAD ANY ALLERGY/SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES? YES / NO (IF YES, PLEASE LIST)

_____ _____ _____

_____ _____ _____

-DO YOU TAKE COUMADIN OR OTHER BLOOD THINNERS? YES / NO -HAVE YOU EVER RECEIVED BLOOD? YES / NO

-DO YOU USE A CPAP MACHINE? YES / NO -DO YOU EXERCISE REGULARLY? YES / NO

WHAT KIND OF WORK DO YOU DO?_____

WHO LIVES AT HOME WITH YOU?_____

ALCOHOL USE: N/A OCCATIONAL USE: BEER,WINE ETC. # OF DRINKS PER DAY _____ PER WEEK_____
STOPPED WHAT YEAR?_____

TOBACCO USE: N/A CIGARETTES, PIPE, CHEW ETC. # OF PACKS_____ PER DAY HOW LONG?_____
STOPPED WHAT YEAR?_____

OTHER DRUGS:_____

FAMILY HISTORY: ANY INHERITED DISORDER OR PROBLEM?_____

MOTHER - ALIVE?_____Y____N MEDICAL PROBLEMS?_____

FATHER - ALIVE? _____Y ____N MEDICAL PROBLEMS?_____

********PATIENT(parent or guardian) SIGNATURE:_____DATE:_____

(Your signature verifies the above is true and accurate)