

SEVEN HILLS SURGICAL ASSOCIATES MEDICAL INFORMATION

Name _____ DOB _____ Today's Date _____

Medications presently taking:

____ SEE ATTACHED LIST

Medication Allergies: _____

Allergic Reaction (if known): _____

Are you allergic to latex? _____

PAST or present illnesses (circle YES or NO):

- | | | | | | |
|-----|----|---------------------|-----|----|-----------------------|
| YES | NO | Migraines | YES | NO | Stomach Ulcers |
| YES | NO | Seizures | YES | NO | Anemia |
| YES | NO | Stroke | YES | NO | Hepatitis |
| YES | NO | Eye Disease | YES | NO | Kidney Disease |
| YES | NO | Thyroid Problems | YES | NO | Diabetes |
| YES | NO | Breast Disease | YES | NO | Arthritis |
| YES | NO | Asthma | YES | NO | Blood clots/phlebitis |
| YES | NO | Bronchitis | YES | NO | Poor circulation |
| YES | NO | Emphysema | YES | NO | Gout |
| YES | NO | Pneumonia | YES | NO | Psychiatric problems |
| YES | NO | Heart Disease | YES | NO | AIDS |
| YES | NO | Rheumatic Fever | YES | NO | Cancer (type _____) |
| YES | NO | High Blood Pressure | YES | NO | Sleep Apnea |
- OTHER _____

Past Operations: _____ Year: _____ Surgeon (if known): _____

Any past problems with anesthesia? No Yes

Do you smoke cigarettes? No Yes
If no, did you smoke in the past? No Yes
Any other tobacco use? _____

How many packs per day? _____
When did you quit? _____
Any alcohol use? _____

Family History (circle):

High Blood pressure
Diagnosis of easy bleeding
Diabetes
Anesthesia problems
Kidney Disease
Aneurysms

Heart Disease
Poor circulation
Lung disease
Cancer (type _____)
Stroke
Other _____

Do you have any of the following NOW (circle YES or NO):

YES	NO	Recent fever/chills	YES	NO	Diarrhea
YES	NO	Recent weight loss	YES	NO	Rectal Bleeding
YES	NO	Skin Rash/Itching	YES	NO	Urinary Problems
YES	NO	New Visual Problems	YES	NO	Backache
YES	NO	Tinnitus (ringing in ears)	YES	NO	Arm or Leg Pain
YES	NO	Nasal Congestion	YES	NO	Arm or Leg Swelling
YES	NO	Recent Sore Throat	YES	NO	Muscle Pain
YES	NO	Cough	YES	NO	Easy Bleeding/Bruising
YES	NO	Shortness of Breath	YES	NO	Swollen Lymph Glands
YES	NO	Chest Pain	YES	NO	Frequent Headaches
YES	NO	Palpitations	YES	NO	Dizziness
YES	NO	Abdominal Pain	YES	NO	Depression
YES	NO	Constipation	YES	NO	Insomnia
YES	NO	Snoring/pause in breathing when sleeping			
YES	NO	Have you ever had a colonoscopy?		If so, when?	_____
YES	NO	Have you ever had chemotherapy or radiation?		If so, when?	_____
YES	NO	Have you ever had hormone replacement therapy?		If so, when?	_____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____