|  |  |  |  |
| --- | --- | --- | --- |
| **Lung** | **Vascular** | **GI/GU/Systemic** | **Systemic/Social** |
| \_\_\_\_Recent Bronchitis | \_\_\_\_Congestive Heart Failure | \_\_\_\_Heartburn/Hiatal Hernia | \_\_\_\_Convulsions/Epilepsy |
| \_\_\_\_Emphysema | \_\_\_\_High Blood Pressure | \_\_\_\_Bladder Problems | \_\_\_\_Parkinson’s (tremors) |
| \_\_\_\_Asthma | \_\_\_\_Mitral Valve/Murmur | \_\_\_\_Prostate Problems | \_\_\_\_Seizures \_\_\_\_Paralysis |
| \_\_\_\_Chronic/A.M. Cough | \_\_\_\_Heart Attack\_\_\_\_yr | \_\_\_\_Ulcers | \_\_\_\_Thyroid Disorder |
| \_\_\_\_Recent Pneumonia | \_\_\_\_Recent Chest Pain | \_\_\_\_Stomach Problems | \_\_\_\_AIDS Exposure |
| \_\_\_\_Shortness of Breath | \_\_\_\_Irregular/Fast Heartbeat | \_\_\_\_Liver Problems | \_\_\_\_Hepatitis: Type\_\_\_\_ |
| \_\_\_\_Tuberculosis Exposure | \_\_\_\_Cardiac Pacemaker | \_\_\_\_Kidney Failure/Dialysis | \_\_\_\_Sleep Apnea □Use CPAP |
| \_\_\_\_Recent Infection “Cold” | \_\_\_\_Cardiac Defibrillator | \_\_\_\_Bowel Problems: | \_\_\_\_Alcohol Use |
| \_\_\_\_Do you smoke? | \_\_\_\_Stroke or Mini Stroke | □ Polyps □ Constipation | How often\_\_\_\_\_\_\_\_ |
| \_\_\_\_Have you ever smoked? | **Mental Health** | □ Diarrhea □ Hemorrhoids | \_\_\_\_Street Drug use |
| How much\_\_\_\_\_\_\_\_ | \_\_\_\_ADD | □ Rectal Bleeding | Diabetes – Controlled by |
| How long\_\_\_\_\_\_\_\_\_ | \_\_\_\_Depression \_\_\_\_Anxiety | □ Family History Colon Cancer | □ Diet □ Insulin |
|  | \_\_\_\_Bipolar Disorder | \_\_\_\_Arthritis  List any medical conditions not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List ALL current medications, doses, and how often you take them (include vitamins, herbs & over the counter medications  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have any allergies to medications? YES NO Please list allergies & reactions:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List prior surgeries and year performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family History: Father: if deceased, at what age? \_\_\_\_\_\_\_\_Medical problems of Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mother: if deceased, at what age? \_\_\_\_\_\_\_Medical problems of Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List medical problems of brothers and sisters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you or your family had any complications with anesthesia? YES NO What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(DO NOT FILL OUT BELOW THIS LINE – TO BE COMPLETED BY PROVIDER)**  **PHYSICAL EXAMINATION**  WT:\_\_\_\_\_\_\_\_\_\_\_HT:\_\_\_\_\_\_\_\_\_\_\_VS: T: \_\_\_\_\_\_\_\_\_\_\_P: \_\_\_\_\_\_\_\_\_\_\_R: \_\_\_\_\_\_\_\_\_\_\_BP: \_\_\_\_\_\_\_\_\_\_\_BMI: \_\_\_\_\_\_\_\_\_\_\_  Chief Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  History of present illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please describe abnormalities below  Please check each item: Normal Abnormal N/A  General Appearance □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Eyes, Ears, Nose, Throat □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Heart □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Lungs □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Abdomen □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GU System □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Extremities □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Spine/Neck □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Neurological □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Indications for Procedure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  RX Given: Percocet Norco Naprosyn Vistaril Tramdol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Risks, benefits and alternatives to surgery discussed with patient  Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Oral Medication |



**HISTORY & PHYSICAL**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location/Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this procedure related to an accident? YES NO Date of Accident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

PATIENT LABEL



Revised 06/2022