##

**Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Medical Staff Only)

Patient Label

**Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH SCREENING:** Please answer the following questions and **explain all yes answers**.

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| Are you currently taking blood thinners? No Yes Have you had an infection after surgery? No YesHave you ever had a blood clot? No Yes Any problems with anesthesia? No Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Complication following surgery? No Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have an allergy to Latex? No YesDo you have a metal allergy? No Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What was your last HA1C? N/A Value: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you use a walker or cane? No Yes Do you use a CPAP machine? No Yes Pressure setting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you live at home alone? No YesAre you pregnant? No YesHave you had a heart attack (MI) within the last 2 years? No YesHave you been hospitalized in the past 6 months? No Yes |

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| **MEDICAL HISTORY:** | Please ensure **ALL** medical conditions are checked or listed |
| ◻️ | Hypertension/High blood pressure  | ◻️ | Diabetes |  |
| ◻️ | Heart disease/coronary artery disease | ◻️ | Rheumatoid arthritis |   |
| ◻️ | Irregular Heartbeat/arrhythmia | ◻️ | Gout |   |
| ◻️ | High cholesterol | ◻️ | Osteoporosis |   |
| ◻️ | Peripheral vascular disease | ◻️ | Thyroid disease |   |
| ◻️ | Stroke | ◻️ | Reflux disease/Heartburn |   |
| ◻️ | Sleep apnea | ◻️ | Stomach ulcers |   |
| ◻️ | Asthma | ◻️ | Cancer |   |
| ◻️ | COPD/Emphysema | ◻️ | kidney disease |   |
| ◻️ | Blood clots/abnormal clotting | ◻️ | HIV/AIDS |   |
| ◻️ | Abnormal bleeding | ◻️ | Hepatitis |   |
| **FAMILY HISTORY:** If **yes** please explain |
| Do you have a family history of blood clots or easily bleeding? No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   |
| Do you have a family history of problems with anesthesia? No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   |
| Any other family history you would like to share? No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **(Medical Staff Only) Vitals: Height\_\_\_\_\_ Weight\_\_\_\_\_ Blood Pressure\_\_\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_ BMI\_\_\_\_\_** |
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| **MEDICATIONS:**  | Please list or attach ***ALL*** prescription ***AND*** over the counter medications  |
| **Name / Dose** | **How often** | **Name / Dose** | **How often** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **MEDICATION ALLERGIES:** | **Please list all allergies and state reaction** |
| **Medication**: | **Reaction** (what happened) | **Medication**: | **Reaction** (what happened) |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **SURGICAL HISTORY:** Please include all surgeries you have had in the past |
| **PROCEDURE:** |  **Year:** | **PROCEDURE:** |  **Year:** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **REVIEW OF SYSTEMS:** | Do you **CURRENTLY** have any of the following conditions |
| General (Fever, chills, weight loss/gain) | No Yes | Digestion (Reflux, ulcers, pain) | No Yes |
| Eyes | No Yes | Bowels (Constipation, diarrhea) | No Yes |
| Ears/Nose/Throat | No Yes | Appetite, Weight gain/loss, weakness | No Yes |
| Heart (Chest pain, palpitations, murmur) | No Yes | Skin (Rashes, sores, itching) | No Yes |
| Lungs, breathing Shortness of breath | No Yes | Balance, dizziness, numbness, tingling | No Yes |
| Please explain all yes answers here:  |  |  |   |
|  |   |   |   |

 **SOCIAL HISTORY:**

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| Marital Status: Married Single Widow(er) Divorced Do you drink alcohol? Yes No How much? (circle) rarely occasionally daily weekly Do you currently smoke, vape or use chewing Tabacco, or pouches? Yes No How much? \_\_\_\_\_ packs per day for \_\_\_\_\_ years Quit (Year you quit: \_\_\_\_) History of substance abuse? Yes No If yes, what substance:Do you use Marijuana? Yes No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewing M.D/PA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_