

7301 E 2nd Street Suite 200 , Scottsdale, AZ 85251

Health Information as of _____ (enter today's date)
 (Please Print Legibly & Fill In or Correct All Fields)

Patient:			
DOB	Age	Marital Status:	Sex: _____
What surgery are you considering?			Weight: _____ lbs
			Height: _____ ft _____ in

DO YOU NOW OR HAVE YOU EVER HAD..... (You must circle an answer for each individual item)

Mitral Valve Prolapse	Yes	No
Anemia	Yes	No
Blood Pressure Abnormalities	Yes	No
Chest Pain/Angina	Yes	No
Heart Attack	Yes	No
Irregular Heartbeats	Yes	No
Congestive Heart Failure	Yes	No
Heart Murmurs	Yes	No
Heart Block	Yes	No
Low Potassium	Yes	No
Abnormal EKG	Yes	No
Pacemaker	Yes	No
Any Heart Disease	Yes	No
Sickle Cell Anemia	Yes	No
Bronchitis	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Asthma	Yes	No
Wheezing	Yes	No
Tuberculosis	Yes	No
Chronic Cough	Yes	No
Abnormal Chest X-Ray	Yes	No
Major Allergies	Yes	No
Chronic Sinus Problems	Yes	No
Any Lung Disease	Yes	No
Blood Clots in your legs	Yes	No
Pulmonary Embolism	Yes	No
Phlebits	Yes	No
Varicose Veins	Yes	No
Tendency to Bleed Easily	Yes	No
Bruise Easy	Yes	No
Blood Clotting Abnormalities	Yes	No
Blood or Plasma Transfusions	Yes	No
Hemophilia	Yes	No
Recurrent Nose Bleeds	Yes	No
Liver Disease	Yes	No
Jaundice or Hepatitis	Yes	No

Stomach Ulcers	Yes	No
Frequent Heartburn	Yes	No
Gastritis	Yes	No
Colitis	Yes	No
Problem Constipation	Yes	No
Vomiting Blood	Yes	No
Tarry or Bloody Bowel Movements	Yes	No
Hemorrhoids	Yes	No
Kidney Disease/Stones	Yes	No
Frequent Bladder Infections	Yes	No
Prostate Problems	Yes	No
Skin Disorders	Yes	No
Rashes	Yes	No
Skin Cancer	Yes	No
Keloids	Yes	No
Steroid Medications	Yes	No
Frequent Boils	Yes	No
Cold Sores/Fever Blisters	Yes	No
Stroke	Yes	No
Epilepsy	Yes	No
Seizures or convulsions or fainting spells	Yes	No
Black outs	Yes	No
Diabetes	Yes	No
Recent Unexpected Weight Loss/Gain	Yes	No
Night Sweats/Fever	Yes	No
Airway Obstruction (Nasal)	Yes	No
Glaucoma	Yes	No
Loss of Vision	Yes	No
Radial Keratotomy	Yes	No
Wear Glasses/Contacts	Yes	No
Arthritis	Yes	No
Bone, Joint, Muscle Problems	Yes	No
Chronic Neck Pain	Yes	No
Chronic Back Pain	Yes	No
Emotional Problems	Yes	No
Aids or HIV Virus	Yes	No
Alcoholism or Drug Dependency	Yes	No

FAMILY HISTORY: Please check all that apply

Breast Cancer
 Tuberculosis
 Epilepsy
 Stroke
 Heart Disease
 Cancer _____
 Bleeding Disorders
 Diabetes
 Asthma
 Lung Disease
 Kidney Disease

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

2. **Do you have an allergic reaction to any medication?** Yes No **Which?** _____

3. Do you react abnormally to any medication? Yes No **Which?** _____

4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?
 Yes No If yes, when and where? _____

5. Have you ever been on cortisone or steroid treatment? Yes No **When?** _____

6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?
 Yes No If so, how much? _____

7. **Do you smoke?** Yes No **If so, how much?** _____ **For how long?** _____

8. Are you pregnant? Yes No **When was your last normal menstrual period?** _____

9. How many pregnancies? _____ Births? _____ Breast Fed? Yes No **How long?** _____

10. When was your last physical exam? _____ **By whom?** _____

11. When was your last eye examination? _____ **By whom?** _____

12. **When was your last mammogram?** _____ **Where was it performed?** _____

13. When and where was your last chest x-ray? _____ **EKG?** _____

14. Who is your personal physician, if any? _____ **Please list all physicians presently caring for you.**

15. Have you ever been under psychiatric care? Yes No **When?** _____ **Why?** _____

16. Have you had any recent blood work done? Yes No **Where?** _____

17. Is there anything else you think the doctor should know? _____

18. **Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:**

SURGICAL OPERATIONS (include where, when and why for each surgery): _____

HOSPITALIZATIONS (include where, when and why for each admission): _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____