Gifford Medical Center

Patient Name: _____

D.O.B.: _____

MR #: _____

Or, Affix Patient Label Here

Anesthesia/Surgery Medical History Intake

Home Phone: _____
Work Phone: _____
Mobile Phone: _____
Gender: ☐ Female ☐ Male
Primary Care Provider: _____

Reason for visit

History of Problem (to be completed by physician)

Medication Allergies

Are you allergic to:

Latex: ☐ Yes ☐ No Peanuts: ☐ Yes ☐ No Eggs: ☐ Yes ☐ No Soy: ☐ Yes ☐ No
Metals: ☐ Yes ☐ No Citrus food: ☐ Yes ☐ No Adhesive tape: ☐ Yes ☐ No

Medications: If you have a list, we would be pleased to make a copy for our records

Drug	Dose	How Often	Prescribing Provider

Check the appropriate box for all questions

Do you suffer from any, or take any of the following:

High blood pressure ☐ Yes ☐ No
Heart disease ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Diabetes mellitus ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Acid reflux ☐ Yes ☐ No
Kidney disease ☐ Yes ☐ No
Plavix ☐ Yes ☐ No
Aspirin ☐ Yes ☐ No
Oral medications for diabetes ☐ Yes ☐ No
Insulin therapy ☐ Yes ☐ No
Coumadin ☐ Yes ☐ No
Depression/Anxiety ☐ Yes ☐ No

Have you ever had:

Tonsillectomy ☐ Yes ☐ No
Hysterectomy ☐ Complete or ☐ Partial ☐ Yes ☐ No
Heart surgery ☐ Yes ☐ No
Angioplasty ☐ Yes ☐ No
Appendectomy ☐ Yes ☐ No
Removal of ovaries ☐ Yes ☐ No
Tubal ligation (tubes tied) ☐ Yes ☐ No
Other surgery: _____ ☐ Yes ☐ No
Vasectomy ☐ Yes ☐ No
Hernia repair ☐ Yes ☐ No
Colonoscopy ☐ Yes ☐ No
Gallbladder surgery ☐ Yes ☐ No
Gastroscopy ☐ Yes ☐ No
Cataract surgery ☐ Yes ☐ No
Bone joint surgery: _____ ☐ Yes ☐ No

Family History

						Children	
Father	Age: _____	☐ Alive	☐ Deceased	Age at death: _____	Cause of death: _____	_____	Age: _____
Mother	Age: _____	☐ Alive	☐ Deceased	Age at death: _____	Cause of death: _____	_____	Age: _____
Brother	Age: _____	☐ Alive	☐ Deceased	Age at death: _____	Cause of death: _____	_____	Age: _____
Sister	Age: _____	☐ Alive	☐ Deceased	Age at death: _____	Cause of death: _____	_____	Age: _____
Brother	Age: _____	☐ Alive	☐ Deceased	Age at death: _____	Cause of death: _____	_____	Age: _____
Sister	Age: _____	☐ Alive	☐ Deceased	Age at death: _____	Cause of death: _____	_____	Age: _____

Has any family member had:

Gallstones ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No
Colitis/Crohn's disease ☐ Yes ☐ No
Breast cancer ☐ Yes ☐ No
Colon cancer ☐ Yes ☐ No
Colon polyp ☐ Yes ☐ No
Uterine cancer ☐ Yes ☐ No
Other cancer: _____
Stomach/esophagus cancer ☐ Yes ☐ No
Prostate cancer ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No

Anesthesia Surgery Medical History Intake.doc cont.

Name of person driving you to the hospital

_____

Relationship: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Patient Name: _____

D.O.B.: _____

MR #: _____

Or, Affix Patient Label Here

Social History:						
Occupation:						
Civil Status:	☐ Single	☐ Married	☐ Widowed	☐ Divorced	☐ Civil Union	
Alcohol Use:	☐ Yes	☐ No	Tobacco Use:	☐ Yes	☐ No	# of cigarettes: _____ Years: _____
Illegal/Significant past substance use history:						

Review of Systems					
General			**HEENT**		
Changes in physical activity	☐ Yes	☐ No	Loose teeth	☐ Yes	☐ No
Recent changes in health	☐ Yes	☐ No	Dentures	☐ Yes	☐ No
Personal or family history of trouble with anesthesia	☐ Yes	☐ No	Difficulty breathing through nose	☐ Yes	☐ No
If yes, please describe:			Difficulty hearing	☐ Yes	☐ No
			Difficulty seeing	☐ Yes	☐ No
			Use of glasses	☐ Yes	☐ No
			Trouble with dry eyes	☐ Yes	☐ No
Respiratory			**Neck**		
Cough	☐ Yes	☐ No	Difficulty with motion	☐ Yes	☐ No
Phlegm/sputum production	☐ Yes	☐ No	Neck injury	☐ Yes	☐ No
Wheezing/Asthma	☐ Yes	☐ No	Difficulty swallowing	☐ Yes	☐ No
Difficulty with breathing	☐ Yes	☐ No	Swollen neck glands	☐ Yes	☐ No
Shortness of breath with exercise	☐ Yes	☐ No	Neck pain	☐ Yes	☐ No
Snoring/Sleep apnea	☐ Yes	☐ No			
Cardiovascular			**Musculoskeletal**		
Chest pain	☐ Yes	☐ No	Difficulty walking	☐ Yes	☐ No
Irregular heartbeat/irregular rhythm	☐ Yes	☐ No	Back pain	☐ Yes	☐ No
Rapid heart beat	☐ Yes	☐ No	Carpal Tunnel Syndrome	☐ Yes	☐ No
Swollen legs/ankles	☐ Yes	☐ No	Difficulty with hands	☐ Yes	☐ No
Unable to lie flat in bed	☐ Yes	☐ No	Difficulty with shoulders	☐ Yes	☐ No
History of varicose veins	☐ Yes	☐ No	Writing hand	☐ **Left**	☐ **Right**
Genitourinary			**Gastrointestinal**		
Kidney stones	☐ Yes	☐ No	Weight loss	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No	Weight gain	☐ Yes	☐ No
Loss of urinary control	☐ Yes	☐ No	Black stool/bloody stool	☐ Yes	☐ No
Urination at night	☐ Yes	☐ No	Acid reflux	☐ Yes	☐ No
Sexual disease	☐ Yes	☐ No	Yellow jaundice	☐ Yes	☐ No
Erectile dysfunction	☐ Yes	☐ No	Nausea/vomiting	☐ Yes	☐ No
Sexual dysfunction	☐ Yes	☐ No	Change in bowel habits	☐ Yes	☐ No
Regular menses – LMP _____	☐ Yes	☐ No			
Menopause	☐ Yes	☐ No			
Pregnant - ☐ No ☐ Yes, Due Date _____	☐ Yes	☐ No			
Skin			**Hematological**		
Rashes	☐ Yes	☐ No	Excessive bleeding after cuts/dental surgery	☐ Yes	☐ No
Cysts/pustules	☐ Yes	☐ No	Easy bruisability	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Blood clots	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No	History of blood transfusion	☐ Yes	☐ No
Change in hair texture	☐ Yes	☐ No			
Change in skin texture	☐ Yes	☐ No			
Lymphatic			**Endocrine**		
Swollen glands under arms	☐ Yes	☐ No	Intolerance to: ☐ Hot ☐ Cold	☐ Yes	☐ No
Swollen glands in legs	☐ Yes	☐ No	Post menopausal vaginal bleeding	☐ Yes	☐ No
Mononucleosis	☐ Yes	☐ No	Hair loss	☐ Yes	☐ No
Disease of immune system	☐ Yes	☐ No	Hot flashes/night sweats	☐ Yes	☐ No
Frequent infection	☐ Yes	☐ No	Thyroid gland disease	☐ Yes	☐ No
Psychological			**Neurological**		
Anxiety	☐ Yes	☐ No	Hand numbness	☐ Left	☐ Right
History of drug/alcohol use	☐ Yes	☐ No	Foot numbness	☐ Left	☐ Right
Stress	☐ Yes	☐ No	Arm/hand weakness	☐ Left	☐ Right
Suicide attempts	☐ Yes	☐ No	Leg/foot weakness	☐ Left	☐ Right
Psychiatric illness	☐ Yes	☐ No	Loss of memory	☐ Yes	☐ No
			Loss of thinking ability	☐ Yes	☐ No

I state that I have honestly and truthfully completed this form.

Patient Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

Updated: _____ Date: _____ Time: _____

Updated: _____ Date: _____ Time: _____