



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

PAST SURGICAL HISTORY:

PLEASE LIST IN ORDER, ANY OPERATIONS YOU HAVE HAD:

|    | DATE  | OPERATION | SURGEON | HOSPITAL NAME |
|----|-------|-----------|---------|---------------|
| 1. | _____ | _____     | _____   | _____         |
| 2. | _____ | _____     | _____   | _____         |
| 3. | _____ | _____     | _____   | _____         |
| 4. | _____ | _____     | _____   | _____         |
| 5. | _____ | _____     | _____   | _____         |

Do you have metal in your body? YES NO - If yes, where? \_\_\_\_\_

FAMILY HISTORY (circle relationship):

| FAMILY MEMBER        | AGE (IF ALIVE) | AGE (IF DECEASED) | CAUSE OF DEATH | SERIOUS ILLNESS (HEART, DIABETES, ETC.) |
|----------------------|----------------|-------------------|----------------|---|
| Father               | _____          | _____             | _____          | _____                                   |
| Mother               | _____          | _____             | _____          | _____                                   |
| Bro/Sis/Son/Daughter | _____          | _____             | _____          | _____                                   |
| Bro/Sis/Son/Daughter | _____          | _____             | _____          | _____                                   |
| Bro/Sis/Son/Daughter | _____          | _____             | _____          | _____                                   |

Has anyone in your family had a tendency to bleed extensively? NO YES

Has anyone in your family had an unusual reaction to anesthesia? NO YES

Has anyone in your family had unexplained fevers following surgery? NO YES

Have you ever had a blood transfusion? NO YES

Is there ANY possibility of your being pregnant at this time? NO YES

HAVE YOU EVER HAD? IF YES, WHEN?

|                         |     |    |       |                   |       |       |       |
|-------------------------|-----|----|-------|-------------------|-------|-------|-------|
| Heart Disease           | YES | NO | _____ | Eye Condition     | YES   | NO    | _____ |
| Heart Attack            | YES | NO | _____ | Ear Condition     | YES   | NO    | _____ |
| Angina                  | YES | NO | _____ | Nose Condition    | YES   | NO    | _____ |
| Chest Pain              | YES | NO | _____ | Throat Condition  | YES   | NO    | _____ |
| High Blood Pressure     | YES | NO | _____ | Tuberculosis      | YES   | NO    | _____ |
| Stroke                  | YES | NO | _____ | Valley Fever      | YES   | NO    | _____ |
| Frequent Headaches      | YES | NO | _____ | Thyroid Disease   | YES   | NO    | _____ |
| Mental Disease          | YES | NO | _____ | Glaucoma          | YES   | NO    | _____ |
| Suicidal Tendencies     | YES | NO | _____ | Drug Addiction    | YES   | NO    | _____ |
| Nerve or Muscle Disease | YES | NO | _____ | Drug Withdrawal   | YES   | NO    | _____ |
| Fainting Spells         | YES | NO | _____ | Kidney Disease    | YES   | NO    | _____ |
| Lung Disease            | YES | NO | _____ | Hepatitis         | YES   | NO    | _____ |
| Bronchitis              | YES | NO | _____ | Diabetes          | YES   | NO    | _____ |
| Asthma or Wheezing      | YES | NO | _____ | Easy Bruising     | YES   | NO    | _____ |
| Emphysema               | YES | NO | _____ | Easy Bleeding     | YES   | NO    | _____ |
| Shortness of Breath     | YES | NO | _____ | Phlebitis         | YES   | NO    | _____ |
| Pulmonary Embolus       | YES | NO | _____ | Obesity           | YES   | NO    | _____ |
| Circulatory Disease     | YES | NO | _____ | Urinary Infection | YES   | NO    | _____ |
| X-Ray Exposure          | YES | NO | _____ | Stomach Ulcers    | YES   | NO    | _____ |
| Radiation Exposure      | YES | NO | _____ | Arthritis         | YES   | NO    | _____ |
| Leukemia                | YES | NO | _____ | Other             | YES   | NO    | _____ |
| Cancer WHERE?           | YES | NO | _____ | Please List:      | _____ | _____ | _____ |

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