

ST. CLAIR SURGICAL SPECIALISTS, P.C.
PATIENT MEDICAL HISTORY

What is your reason for today's visit: _____
 When did this problem begin? _____
 Has there been any change in this problem? (circle one) Yes No
 What? _____ How Long? _____

HEALTH HISTORY:

	YES	NO	
Are you in good health?	___	___	
Have there been any changes to your general health in the past year?	___	___	
Have you had an operation or been hospitalized in the past 5 years?	___	___	
Do you smoke?	___	___	if yes, how much _____
Do you drink alcohol?	___	___	if yes, how much _____
Is your condition the result of an injury on the job?	___	___	Date: _____
Is your immune system suppressed by disease or medication?	___	___	

Have You Had or Do You Currently Have:

	Yes	No		Yes	No
Heart trouble (mitral valve prolapse)	___	___	Constipation	___	___
Heart Attack	___	___	Liver disease or jaundice	___	___
Chest Pain, angina	___	___	Hepatitis	___	___
Heart Surgery/Bypass/Stents	___	___	Stomach ulcers/GERD	___	___
Cardiac Pacemaker	___	___	Gallbladder disease	___	___
Heart murmur/Arrhythmia	___	___	Kidney trouble	___	___
Rheumatic Fever	___	___	Epilepsy/seizures	___	___
Vascular Surgery	___	___	Delay in healing	___	___
Stroke	___	___	Chronic fatigue/night sweats	___	___
High Blood Pressure	___	___	Diabetes	___	___
Difficulty breathing	___	___	Artificial joints	___	___
Asthma	___	___	Placed when? _____		
Hay fever/sinus problems	___	___	Arthritis/rheumatism	___	___
Emphysema/COPD	___	___	Glaucoma/eye disease	___	___
Bronchitis/chronic cough	___	___	Thyroid trouble	___	___
Tuberculosis	___	___	Mental Health problems	___	___
Anemia	___	___	History of alcohol abuse	___	___
Leukemia	___	___	History of drug abuse	___	___
Cancer	___	___	Surgery	___	___
Type: _____			Type: _____		
Radiation/chemotherapy	___	___			
Porphyria (blood disorder)	___	___	Date(s): _____		

Family History – Is there a family history of:

	Yes	No
Anesthetic problems	___	___
Bleeding disorders	___	___
Diabetes	___	___
Heart disease	___	___
Kidney disease	___	___
Systemic Lupus	___	___
Cancer of breast, colon, ovaries, or prostate	___	___

Notes/When

Medications: Please list all medications and herbal/vitamin supplements that you take on a daily basis.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Allergies: Are you allergic to, or have you ever had a reaction to any of the following:

	Yes	No	Reaction
Penicillin	___	___	_____
Other Antibiotics	___	___	_____
Acetaminophen (Tylenol)	___	___	_____
Sedatives/sleeping pills	___	___	_____
Food Allergies	___	___	_____

	Yes	No	Reaction
Aspirin	___	___	_____
Sulfa drug	___	___	_____
Codeine	___	___	_____
Other medicine	___	___	_____
Latex	___	___	_____
Iodine	___	___	_____
CT scan contrast	___	___	_____

Anesthesia

	Yes	No	Notes
Have you ever had general anesthesia:	___	___	_____
Have you ever had a reaction to general or local anesthesia	___	___	_____

Signature of Patient: _____ **Date:** _____
(Parent or guardian if patient is a minor)

Reviewed with patient: _____ **Date:** _____