

# Medical/Surgical History

**\*\*PLEASE FILL OUT COMPLETELY\*\***

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_  
**Procedure(s):** \_\_\_\_\_ **Surgeon: Sarah C. Troxel, M.D.**

*In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion, such information may critically affect what procedure(s) we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information:*

<b>Age:</b>	<b>Height:</b>	<b>Weight:</b>	<b>Occupation:</b>
<i>Please list <u>all</u> medications which you are currently taking and/or have used in the past 6 months. Be sure to include any of the following: Birth control pills, Aspirin or Ibuprofen containing drugs, Phen-Fen, St. John's Wart, Redux, Diabetic medications, Steroids, Glaucoma drops, Asthma Medications, Digoxin, Lanoxin, Nitroglycerin, Isordil, Inderal, Other Heart Medications, Lasix, Other Diuretics, High Blood Pressure Medications, Coumadin, Persantine, Tranquilizers, Sleeping Pills, Anti-Depressants, Pain Pills or Shots, Epilepsy Medications.</i>			
<b><u>MEDICATION(S):</u></b>		<b><u>AMOUNT/FREQUENCY:</u></b>	
_____			
_____			
<b><u>LIST ALL DRUG ALLERGIES:</u></b>			
_____			
<b>Have you ever used (circle): LSD/SPEED/COCAINE/MARIJUANA?</b>			<b>NEVER</b>
<b>Are You a Smoker? YES/NO</b>		<b>Ex-Smoker YES/NO</b>	
<b>Are You a Smoker? YES/NO</b>		<b>Non-Smoker YES/NO</b>	
<b>How much are/were you smoking?</b>		<b>How long?</b>	
<b>How much alcohol do you drink?</b>		<b>Quit how long ago?</b>	
<b>How much alcohol do you drink?</b>		<b>Caffeine?</b>	
<i><b>Please circle all of the following medical conditions you now have or have had in the past:</b></i>			
<b>Bleeding Tendency / Blood Clots / Hepatitis / Diabetes / Blood Transfusions / Glaucoma / Dry Eyes / Lung Disease /TB/ Asthma / Wheezing / Emphysema / Bronchitis / Irregular Heart Beat / Chest Pain / Heart Disease / Stroke/ Heart Attack/ Epilepsy / Heart Burn / Intestinal Ulcers or Bleeding / Depression / Mental Illness / High Blood Pressure/ Hypertension/ Cancer/ Drug or Alcohol Addiction / Any Other Serious Illness or Injury / NONE OF THE ABOVE</b>			
<b>Is there any possibility that you may be pregnant at this time?</b>			<b>YES/NO</b>
<b>List ALL surgeries that you have had including plastic surgery and the dates performed:</b>			
_____			
_____			
<b>Have you or anyone in your family ever had an unusual reaction to anesthesia (muscle weakness, jaundice, breathing problems, unexpected fevers)?</b>			
<b>YES/NO</b>			
<b>Do you have (circle): Loose or Chipped Teeth / Caps / Dentures / Contact Lenses / NONE</b>			
<b>Have you ever seen a cardiologist?</b>		<b>Physician' Name:</b>	
<b>YES/NO</b>			
<b>Date of last EKG / ECG:</b>			

<b>Patient Signature:</b>	<b>Date:</b>
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