PATIENT INFORMATION SUMMARY

Name: ______________________ Date of Birth: __________ Gender: __________ Blood Type: ______

Home Address: ____

Employer: ______________________ Occupation: ______________________

Employer Address: ____

Emergency Contact Name: ______________________ Emergency Contact Phone: ______________________

MEDICAL INSURANCE

Primary Insurance Name: ______________________ Primary Insurance Phone: ______________________

Policyholder's Name: ______________________ Relationship to Patient: ______________________

Member ID #: ______________________ Group #: ______________________

Secondary Insurance Name: ______________________ Secondary Insurance Phone: ______________________

Policyholder's Name: ______________________ Relationship to Patient: ______________________

Member ID #: ______________________ Group #: ______________________

PHYSICIAN CONTACT INFO

Physician Specialty: ______________ Name: ______________ Phone: ______________

Physician Specialty: ______________ Name: ______________ Phone: ______________

Physician Specialty: ______________ Name: ______________ Phone: ______________

Physician Specialty: ______________ Name: ______________ Phone: ______________

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PATIENT INFORMATION SUMMARY

Name: ______________________ Date of Birth: __________ Gender: __________ Blood Type: ______

MEDICAL HISTORY

Check any conditions you have had:

- [ ] High Blood Pressure
- [ ] **Heart Condition**
  - [ ] Heart attack. When: ______________________
  - [ ] Chest pain/pressure/angina.
    When was the last time: ______________________
  - [ ] Shortness of breath
  - [ ] Heart failure or fluid in your lungs
  - [ ] Irregular heart beats
  - [ ] Heart murmur or heart valve
  - [ ] Congenital heart disease (born with).
    Specify: ______________________
- [ ] Heart surgery or angioplasty or heart stents placed
- [ ] Heart tests
  - [ ] Stress test (treadmill)
  - [ ] Heart catheterization
  - [ ] "Echo"/heart ultrasound
  - [ ] "Holter" heart rhythm monitor
- [ ] Pacemaker
- [ ] Internal defibrillator
- [ ] Other heart conditions: ______________________
- [ ] **Breathing/Lung Condition**
  - [ ] Emphysema
  - [ ] Breathing tube placed. When: ______________________
  - [ ] Asthma
  - [ ] Wheezing
  - [ ] Sleep apnea
  - [ ] Blood Clot to lungs (pulmonary embolism)
  - [ ] Use oxygen at home. Amount: ______________________
- [ ] Other lung problems: ______________________
- [ ] **Liver Condition**
  - [ ] Hepatitis. Type: ______________________
  - [ ] Cirrhosis of the liver
  - [ ] Other liver problems: ______________________
- [ ] **Kidney Problems**
  - [ ] Type: ______________________
  - [ ] On dialysis
- [ ] **Diabetes**
  - [ ] Take Insulin
- [ ] **Endocrine Problems**
  - [ ] Hot or cold intolerance
  - [ ] Thyroid problems
  - [ ] Neck irradiation history
- [ ] **Neurological Condition**
  - [ ] Had a stroke or TIA ("mini-stroke")
  - [ ] Seizure disorder or epilepsy
  - [ ] Headaches
  - [ ] Other neurological conditions: ______________________
- [ ] **Rheumatoid Arthritis**
  - [ ] Symptoms affecting your neck
- [ ] **Blood Disorder**
  - [ ] Anemia (low blood count)
  - [ ] Sickle cell disease
  - [ ] Abnormal bleeding/bruising
  - [ ] Tendency to form blood clots
  - [ ] Past blood transfusion. When? ______________________
  - [ ] Other blood disorders: ______________________
- [ ] **Gastrointestinal Problems**
  - [ ] Loss of appetite. Explain: ______________________
  - [ ] Change in bowel movements. Explain: ______________________
  - [ ] Nausea or vomiting. Explain: ______________________
  - [ ] Frequent diarrhea?
  - [ ] Constipation. Explain: ______________________
  - [ ] Rectal bleeding or blood in stool.
    Explain: ______________________
  - [ ] Abdominal pain. Explain: ______________________
  - [ ] Stomach ulcers (peptic ulcer disease).
    Explain: ______________________
  - [ ] Frequent gastroesophageal reflux (GERD) or heartburn
- [ ] **Cancer**
  - [ ] Type: ______________________
  - [ ] Chemotherapy.
    Dates/type (if known): ______________________
  - [ ] Radiation therapy.
    Dates: ______________________
- [ ] **Metal Implants or Devices**
  Explain: ______________________

PATIENT INFORMATION SUMMARY (3 OF 3)

Name: ______________________ Date of Birth: __________ Gender: __________ Blood Type: ______

SURGICAL HISTORY

Have you ever had surgery? Yes No

If yes, please list:

Type: ____________________ Year: __________

Type: ____________________ Year: __________

Type: ____________________ Year: __________

Recent Hospitalizations: ____________________

Problems with nausea/vomiting after anesthesia

Problems with difficult breathing tube insertion

Problems with awareness under anesthesia

Family history of malignant hyperthermia

Family history of major anesthesia problems.
Please list date, type of surgery, and hospital
surgery took place:

____

PSYCHIATRIC HISTORY

Anxiety

Memory change

Depression

Suicidal ideation

Mood swings

Homicidal ideation

Sleep disturbances

Hallucinations (A/V)

Other: __________

Explain:

____

ALLERGIES

Are you allergic to any medications? Yes No

If yes, please list: ____________________

Are you allergic to latex? Yes No

Are you allergic to any foods? Yes No

If yes, please list: ____________________

FOR WOMEN ONLY

Are you pregnant?	Yes	No
Trying to get pregnant?	Yes	No
Nursing?	Yes	No
Postpartum depression?	Yes	No
Taking oral contraceptives?	Yes	No
Menopause?	Yes	No