

Current Height: _____ **Current Weight:** _____ **lbs.**

Past Medical History:

Surgeries / Hospitalizations	Year
Illnesses/Injuries not described?	

Have you ever had general anesthesia? Yes No
 If yes, have you had any problems with anesthesia? Yes No Describe: _____

Family History:

Member	Alive/Deceased	Age	Health Status or Cause of Death
Father	A / D		
Mother	A / D		
Sister/Brother	A / D		
Sister/Brother	A / D		

Do you have a family history of bleeding problems? Yes No
 Do you have a family history of anesthetic problems? Yes No

Social History:

Work at Home _____ Employed (Occupation) _____ Student _____

Are you working now? Yes No Last Date Worked _____

Full Time _____ Part Time _____ Retired _____ Unemployed _____

Disabled: Total _____ Partial _____ Workers Compensation _____ Disability Policy _____

Are you off work due to this problem? Yes No
 Are you off work due to another problem? Yes No
 Have you lost time previously due to this injury? Yes No

Children? Yes No # _____

Do you live alone? Yes No

Are you on a special diet? Yes No Describe: _____

Do you have a history of substance abuse? Yes No Substance: _____

Do you currently smoke? Yes No _____ Packs per day for _____ years

Have you quit smoking? Yes No This year > 1 year > 5 years > 10 years

Previously smoked _____ Packs per day for _____ years

Do you drink alcohol? Yes No Daily 1 – 2 x per week 1 – 2 x per month More

Highest level of Education reached Finished High School Some College Finished College _____
 Graduate Degree Other

Reviewed by: _____ M.D. **Date:** _____