EVERGREEN SURGICAL MEDICAL HISTORY FORM

Thank you for providing us with the following information:

		DATE
Name:	DOB:	Age:
Which MD are you seeing today? ☐ Immerman ☐ Wogahn ☐ Daniels ☐ Asplund ☐ Andrew		
Who is your family physician?	*Office Staff Only:*	
Who is referring you to us today?	WT	HT
What problem or concern brings you to see us?	BP	Pulse
		Resp

Have you ever had...

any problems with anesthesia before? ☐ No ☐ Yes
If yes, please explain:

unusual Bleeding during surgery? ☐ No ☐ Yes
If yes, please explain:

Are you currently on "blood thinners" or anti-coagulant medication, including aspirin? ☐ No ☐ Yes
If yes, which medication: _____

Have you ever had a MRSA or resistant staph infection? ☐ No ☐ Yes

☐ check here if your religious beliefs prohibit blood transfusions

Have you ever had surgery before?

✔	Operation	~ Year Done	✔	Operation	~ Year Done
	Appendectomy			Orthopedic Surgery	
	Gallbladder Removal			Caesarean Section	
	Heart Surgery			Hysterectomy	
	Prostate Surgery			Back Surgery	
	Hernia Repair			Tonsillectomy	
	Breast Surgery			Other:	
	Pacemaker/Defibrillator (note date/cardiologist):				

What is your preferred pharmacy? (List name and location)

Medication Allergies/Reactions: _____

CURRENT MEDICATIONS

DRUG NAME (include non-prescription or "over the counter" medications you take with any regularity)	**DOSE**	**HOW OFTEN TAKEN**	**REASON FOR MEDICINE**

OVER ▶

FAMILY HISTORY: Are there any medical problems that run in your family? ❑ no ❑ yes, please explain:
Mother: Father: Siblings (Brothers/Sisters):

List any diseases which caused significant illness or death of a parent or sibling in your family: (if not listed above)
Mother: Father: Siblings:

For Female Patients Only: Have any women on your mother's side of your family had breast cancer? ❑ no ❑ yes, list relationship to you:

Do you wear: ❑ glasses/contacts to correct vision ❑ wear hearing device
Dentures: ❑ upper ❑ lower ❑ partial ❑ prosthesis: (describe)

Do you currently have any of the following medical problems, or have you experienced any of these problems?

❑ Diabetes ❑ Heart Disease ❑ High Blood Pressure ❑ Stroke ❑ Heart Attack ❑ Seizures
❑ Arthritis ❑ Blood clots in legs ❑ Kidney Disease ❑ Asthma ❑ Emphysema ❑ Blood clots in lungs
❑ Cancer (type): ❑ Chronic Sinus Problems ❑ Other:

Are you currently bothered by or have you noticied:

❑ Constipation	❑ Headache	❑ Joint Pain	❑ Painful passing of urine	❑ Breast Pain
❑ Diarrhea	❑ Dizziness	❑ Joint Stiffness	❑ Difficult urination	❑ Breast Discharge
❑ Blood in your stool	❑ Forgetfulness	❑ Fever	❑ Frequent Urination	❑ Breast lump
❑ Stomach Pain	❑ Blurred vision	❑ Trouble walking	❑ Blood in your urine	
❑ Heartburn	❑ Double vision	❑ Swelling of feet	❑ Impotence/sexual concerns	
❑ Vomiting	❑ Depression	❑ Chest pain		
❑ Loss of Appetite	❑ Insomnia	❑ Cough	❑ Cuts slow to heal	
❑ Trouble Swallowing	❑ Hearing Loss	❑ Wheezing	❑ Skin Rashes	If female, are you having
❑ Recent unexplained weight loss	❑ Earaches	❑ Shortness of Breath	❑ Bleeding frequently	menstrual periods?
	❑ Ear Drainage	❑ Coughing up Blood	❑ Bruising frequently	❑ Yes ❑ No

Any other problems not listed above?

Habits: Do you smoke? ❑ no - never
❑ no - but I did in past--When(list approx age begun): _____ and how long (# of years): _____
❑ yes - if yes, how many packs/day? _____ since what age? _____
Do you use smokeless tobaccco? ❑ yes ❑ no
Do you drink alcohol? ❑ rarely or not at all ❑ average of 1-2 x/wk ❑ daily or almost daily: how much/day:_____

Labs & Tests Done Recently: check if:	Specify where this/these tests were done:
❑ you've had an EKG in the last 6 months	
❑ recent x-rays (what kind):	
❑ any blood tests in last 4 weeks	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing misleading or inaccurate information can adversely affect my medical care. It is my responsibility to inform my physicians of any changes in my health status.

*Patient Signature:*_____ *Date:*_____

If patient did not complete the above form, please list who provided the information and their relationship to the patient:

Signature:_____ Relationship to patient:_____