

Name Cassie Meyer

Date of birth 10/10/99

Have you **EVER** had any of the following?

**Medical:**

- |                                            |                                                   |                                                  |
|--------------------------------------------|---------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Endometriosis            | <input type="checkbox"/> Multiple sclerosis      |
| <input type="checkbox"/> Adrenal disorders | <input type="checkbox"/> Eye disorders            | <input type="checkbox"/> Mumps                   |
| <input type="checkbox"/> Alcohol abuse     | <input type="checkbox"/> Fractures/broken bones   | <input type="checkbox"/> Muscular dystrophy      |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Genital warts            | <input type="checkbox"/> Paget's disease of bone |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Gonorrhea                | <input type="checkbox"/> Pneumonia               |
| <input type="checkbox"/> Anorexia          | <input type="checkbox"/> Headaches                | <input type="checkbox"/> PCOS                    |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Hearing loss             | <input type="checkbox"/> Pregnancy               |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Psoriasis               |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> Radiation therapy       |
| <input type="checkbox"/> Bladder disease   | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Herpes                   | <input type="checkbox"/> Sinusitis (chronic)     |
| <input type="checkbox"/> Bulimia           | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hives                    | <input type="checkbox"/> Thyroid disease         |
| <input type="checkbox"/> Celiac disease    | <input type="checkbox"/> HPV                      | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Chlamydia         | <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Typhoid fever           |
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Ulcerative colitis      |
| <input type="checkbox"/> Concussion        | <input type="checkbox"/> Mononucleosis            | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Chicken pox             |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Kidney stones            |                                                  |
| <input type="checkbox"/> Eczema            | <input type="checkbox"/> Malaria                  |                                                  |

**Anesthesia History:**

- ☐ Difficult intubation
- ☐ Malignant hyperthermia
- ☐ Pseudocholinesterase deficiency
- ☐ Spinal headache

☒ I've had NO significant health problems

**Surgical:**

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Ear tubes
- ☐ Knee ACL tear
- ☐ Knee arthroscopy
- ☐ Organ transplant
- ☐ Ovarian cyst removal
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight loss surgery

☒ Other surgical history:  
Wisdom teeth

**Family History:**

Alcohol abuse   Clotting disorder   Breast cancer   Colon cancer   Melanoma cancer   Other cancer: \_\_\_\_\_   Diabetes   Drug dependency   Heart disease   High cholesterol   High blood pressure   Learning disabilities   Mental illness   Stroke   Sudden cardiac arrest

|                      |                                     |                          |                          |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|----------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Mother               | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Father               | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sister               | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brother              | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maternal Grandfather | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maternal Grandmother | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Paternal Grandfather | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Paternal Grandmother | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maternal Aunt        | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maternal Uncle       | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Paternal Aunt        | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Paternal Uncle       | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

☐ Adopted   ☐ Family history unknown