

Name Angela Russell Date of Birth 7/13/89PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs ☐ Asthma ☐ Heart Disease (<i>valve, vessel, rheumatic, etc.</i>) ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Pneumonia	Stomach/Bowel ☐ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Stomach/Duodenal Ulcers ☐ Ulcerative Colitis/Crohn's ☐ Other Liver, Stomach, or Bowel Disease Neurological ☒ Concussions ☐ Convulsions/Seizures ☒ Migraines/Severe Headaches ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Stroke/TIA	Hematology/Oncology ☐ Anemia ☐ Bleeding Disorders ☐ Blood Clots/Clotting Disorders ☐ Cancer ☐ Radiation Therapy Orthopedics ☐ Arthritis ☒ Fractures/Broken Bones Infectious Diseases ☒ Chickenpox/Varicella ☐ Hepatitis Type: ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever Skin ☐ Eczema ☐ Psoriasis ☐ Hives	Anesthesia History ☐ Difficult intubation ☐ Malignant hyperthermia ☐ Post Op Nausea or Vomiting (PONV) ☐ Pseudocholinesterase Deficiency ☐ Spinal headache Surgical History ☐ Appendectomy ☐ Adenoidectomy ☐ Ear Tubes ☐ Gallbladder Removal ☐ Knee ACL Repair ☐ Knee Arthroscopy ☐ Organ Transplant ☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☒ Other Prior Surgeries	STDs ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD OB/GYN History ☐ Endometriosis ☐ Pregnancies #: Exercise History ☐ Lack of exercise ☐ Exercising regularly Moderate Exercising <i>Walking briskly, water aerobics, etc.</i> ☒ Less than 3 times per week ☐ 3 or more times per week Strenuous Exercising <i>Running, swimming laps, etc.</i> ☐ Less than 3 times per week ☐ 3 or more times per week
Endocrine ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder	☐ Stroke/TIA	☐ HIV Infection	☐ Knee ACL Repair ☐ Knee Arthroscopy	☐ Less than 3 times per week
Kidney ☐ Chronic Kidney or Bladder Disease ☐ Kidney Stones	Mental Health ☐ ADHD ☐ Alcohol Abuse ☒ Anorexia (<i>Eating Disorder</i>) ☒ Anxiety Disorder ☐ Bulimia (<i>Eating Disorder</i>) ☒ Depression ☐ Drug Dependency ☒ Other Mental Health Problems	☐ HIV Infection	☐ Knee ACL Repair ☐ Knee Arthroscopy	☐ Less than 3 times per week
Ears/Eyes/Nose/Throat ☐ Chronic Sinus Infections ☐ Eye Disorders (<i>other than glasses or contacts</i>) ☐ Hearing Loss ☐ Nasal Allergies/Hayfever	☐ Stroke/TIA	☐ HIV Infection	☐ Knee ACL Repair ☐ Knee Arthroscopy	☐ Less than 3 times per week

☒ NO Significant Health Problems

Last Medications

Allergies

Have you ever had an allergic reaction? ☒ Yes ☐ No

Medication Allergies: _____

Food Allergies: _____

Other Allergies (latex, bee stings, etc.): bee stings

Other History

☐ Previous Hospitalizations _____☐ OTHER Health Problems _____

Does YOUR IMMEDIATE FAMILY have any of the following?

☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Alcoholism				
Blood Clots/Clotting Disorders				
Cancer				yes G-M-M yes G-F-M
Breast				
Colon				
Melanoma	yes			
Other Cancers (List Type)				
Diabetes				yes G-M-M
Drug Dependency				
Heart Disease				yes G-F-P
High Blood Pressure		yes		yes G-P-A
High Cholesterol				yes G-P-P
Mental Illness				
Stroke				yes G-M-P
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				
Parent Deceased				