

Name Ana FosterDate of Birth 2/11/69PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

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

No Significant Health Problems

No Medications

Allergies

Have you ever had an allergic reaction? ☐ Yes ☒ NoMedication Allergies: *Sugarair - 1 dose daily*Food Allergies: *n/a*Other Allergies (latex, bee stings, etc.): *n/a*

Other History

☐ Previous Hospitalizations *C-sections (2) 1998 and 2002*☐ OTHER Health Problems

Does YOUR IMMEDIATE FAMILY have any of the following?

☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Alcoholism	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Blood Clots/Clotting Disorders	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Cancer	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Breast				
Colon				
Melanoma				
Other Cancers (List Type)				
Diabetes				
Drug Dependency				
Heart Disease				
High Blood Pressure		<i>yes</i>		<i>yes - Grandpa</i>
High Cholesterol				
Mental Illness				
Stroke				
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				
Parent Deceased	<i>Alzheimers</i>	<i>yes</i>		<i>Alzheimer's Grandmother</i>