

Name Toby J. Killcreas Date of Birth 6/16/1985
 PAST/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 ☐ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Stomach/Duodenal Ulcers ☐ Ulcerative Colitis/Crohn's ☐ Other Liver, Stomach, or Bowel Disease	Hematology/Oncology ☐ Anemia ☐ Bleeding Disorders ☐ Blood Clots/Clotting Disorders ☐ Cancer ☐ Radiation Therapy	Anesthesia History ☐ Difficult intubation ☐ Malignant hyperthermia ☐ Post Op Nausea or Vomiting (PONV) ☐ Pseudocholesterase Deficiency	STDs ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD
Endocrine ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder	Neurological ☐ Concussions ☐ Convulsions/Seizures ☐ Migraines/Severe Headaches ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Stroke/TIA	Orthopedics ☐ Arthritis ☐ Fractures/Broken Bones	Surgical History ☐ Appendectomy ☐ Adenoidectomy ☐ Ear Tubes ☐ Gallbladder Removal ☐ Knee ACL Repair ☐ Knee Arthroscopy ☐ Organ Transplant	OB/GYN History ☐ Endometriosis ☐ Pregnancies #:
Kidney ☐ 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 <i>Shingles</i> ☒ Chickenpox/Varicella ☐ Hepatitis Type: ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever	☐ 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 ☐ Chronic Sinus Infections ☐ Eye Disorders (other than glasses or contacts) ☐ Hearing Loss ☐ Nasal Allergies/Hayfever		Skin ☐ Eczema ☐ Psoriasis ☐ Hives		

☒ NO Significant Health Problems

List Medications

Allergies

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

Medication Allergies: Augmentin

Food Allergies:

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

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	Breast			☒
	Colon			
	Melanoma			
	Other Cancers (List Type)			<u>Pancreatic</u>
Diabetes		<u>Borderline</u>		☒
Drug Dependency				
Heart Disease				
High Blood Pressure		☒		☒
High Cholesterol		☒		☒
Mental Illness				
Stroke		☒		☒
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)	<u>Benign tumor</u>			
Parent Deceased				